The Canadian Nurse

Registered at Ottawa, Canada, as second class matter.

Editor and Business Manager:
ETHEL JOHNS, Reg. N., 1411 Crescent Street, Montreal, P.Q.

CONTENTS FOR OCTOBER, 1941

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MEDICINE,
too, had its heroic days

THE "gilded cage" of ten to twenty bedrooms, with but a single small, ill-ventilated "water-closet," held many a martyr to constipation or its alternative of the mid-Victorian era: Grandma's nauseating brews, or the doctor's unrefined castor oil or calomel.

With the passing of heavy red flannel underwear, the treatment of constipation has also emerged from its early crudity. Out of the welter of professional opinion for the most satisfactory modern treatment of this ever prevalent condition, crystallized the Agarol idea—a mineral oil and agar emulsion suitable for every age period and in every pathologic condition where an intestinal evacuant is indicated.

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Reader's Guide

In spite of their reputation for conservatism, the British move quickly once they are convinced that change is necessary and desirable. It sometimes happens that change in Britain is reflected in other parts of the Commonwealth. For that reason, **Significant Trends in Britain** may prove to be worthy of your attention.

The *Journal* is indebted to the Manitoba Association of Registered Nurses for sharing with our readers the excellent address given by **Dr. A. F. Menzies** at a joint meeting of the three sections of the Association. In addition to carrying on a large practice in the surrounding district, Dr. Menzies is also superintendent of the Morden Hospital. He is a keen student and actively interested in research. His stimulating discussion of the characteristics of the soil in relation to nutrition is both timely and highly original.

Many favourable comments were made upon the article on nursing aspects of radiology by **Claribel McCorquodale** which appeared in the September number of the *Journal*. In the current issue, she discusses radiotherapy in relation to the patient and presents some more of her excellent illustrations. Miss McCorquodale is supervisor of nurses in the department of radiology of the Toronto General Hospital.

There was such an excellent response to a previous article by **Dr. N. L. Burnette** that we persuaded him to continue his delvings into Canadian history. In "Bridget writes home", he tells us how Canada looked to a lively Irish girl more than a hundred years ago. Dr. Burnette is assistant secretary of the Welfare Division of the Metropolitan Life Insurance Company.

Under the intriguing title of "The Five Rites", **Jean M. Drummond** presents an interesting commentary on the action of some of the new drugs. Miss Drummond is a private duty nurse and practises her profession in Vancouver. This excellent article is sponsored by the General Nursing Section of the Canadian Nurses Association.

The activities carried on by the Health Units of Cape Breton Island are outstanding examples of what can be done to improve conditions in the rural districts. In her capacity as supervisor of nurses, **Hazel R. C. Macdonald** gives a vivid picture of the enterprise as a whole and **Kaye Macneil** tells us about the daily work of the public health nurses who take part in it.

The speeding up of industrial activity in Canada will inevitably increase the risk of accidents. **Mr. R. B. Morley** describes the measures taken in Ontario to prevent injuries whenever possible and to safeguard the interests of the worker should they occur. This article is the substance of an address delivered before the members of District 5, R.N.A.O., by Mr. Morley who is general manager of the Industrial Accident Prevention Association.

Although next June may seem rather far away, the Biennial Meeting of the Canadian Nurses Association will be coming along before we realize it. In **Notes from the National Office** there are some excellent suggestions about what must be done to make the meeting thoroughly worthwhile.

Among the eight Nursing Sisters shown in the illustration on the cover are Margaret Smith (Sister-in-charge), and Nursing Sisters Kathleen MacLeod ,Margaret Hawkesworth, Erna Murray, Jean Blenkhorn, Billie Bell, Delia Ouellet, and Jean Rayworth. They are members of the **Nursing Staff of No. 6 Casualty Clearing Station, R.C.A.M.C.,** and all are graduates of the School of Nursing of the Royal Victoria Hospital, Montreal. The *Journal* is very grateful to The Montreal Star for allowing us to use this striking photograph.

The
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OCTOBER, 1941

Significant Trends in Britain

Owing to the extensive damage done to British hospitals by enemy action, changes are taking place which will profoundly affect nursing service and education. Great hospitals, such as St. Thomas's, Guy's, and "the London", have been damaged so severely that they have been obliged to abandon their original buildings, either in whole or in part, and to establish themselves out in the country in what are called "sectors". It has even been suggested that when this war is over, these sectors will become permanent and that the parent institutions in the great cities will serve only as administrative centres and emergency wards.

Changes such as these must inevitably modify the policies, organization and administration of schools of nursing and, when the Royal College of Nursing recently celebrated its Silver Jubilee, it is significant that the occasion was marked more by forecasts of the future than by recollections of the past. Among the speakers was Dr. Harold Balme, whose provocative study, "A Criticism of Nursing Education", set everyone thinking even before the war. At the risk of being labelled an Utopian, Dr. Balme put forward the following challenging ideas:

"Let us imagine we had the plan and could apply it in one district, say Birmingham, as here there is a movement to get together in one hospital centre all types of hospital work. What should I do if I could plan as I wished there? I should set up a Nursing College in the ordinary sense of the word, affiliated to the University of Birmingham. I should have post graduate courses there, re fresher courses, sister tutor courses, courses in hospital administration, and public health. I should arrange a collegiate type of training for nurses, of the rank of the secondary school teacher's training, for girls willing to pay something for their professional education because of the status and the financial re-

turn it would yield. The student would take the ordinary course, consisting largely of practical work, but this practical work would be taken from the point of view of the training required by the students. They would not be tied to one hospital, but would go to various hospitals for varying types of practical work. They would work in groups. They would have lectures, demonstrations and perhaps three or four hours' practical work a day. In some hospitals there would be no student nurses; all would be paid nurses. In others, because there was excellent teaching material, there would be some paid and some student nurses. I should see that the student nurse got enough work of each type, and did not do more just because someone had to do it. If such a scheme were worked out in a district, coupled with a proper scheme for salaries and pension, I believe it would succeed in attracting large numbers of students of an intelligent and capable type."

Another speaker upon this occasion was Miss G. B. Carter, author of the stimulating volume, "A New Deal for Nurses". The essence of her thinking was summed up in three resolutions which she placed before the meeting:

1. That this meeting of members of the Royal College of Nursing calls upon the Council of the College to ask the Government to give a pledge forthwith that, in order to secure the proper protection both of the public and of trained nurses, it shall be made *illegal*, as soon as practicable, for any person to practise nursing habitually unless registered as a nurse.

2. That, in order to make available a sufficient service of properly trained nurses, the General Nursing Council be required to make *immediately* a Roll of Assistant Nurses to consist of nurses already in practice as assistant nurses, and of nurses subsequently to be admitted after prescribed training and tests.

3. That, in view of the urgent problems involved in the provision of adequate nursing and public health services of national scope, the time is ripe for all those sharing in those services, whether as employers or employed, to get together and work out solutions acceptable to themselves and to the public. This meeting, therefore, urges the Council of the Royal College of Nursing to take steps, in consultation with the Ministries of Labour and Health, to set up the necessary joint bodies to consider the rights and duties of the nursing profession as a whole.

Recent issues of the *Nursing Times* have also featured articles presenting new schemes for the education of nurses. One of these was written by Miss Daisy Bridges, who is well known to Canadian nurses. Another was prepared by Miss J. M. Calder, superintendent of health visitors in the city of Manchester. Both advocate sweeping changes, especially in relation to the public health content of the course. Miss Calder suggests that schools of nursing should be administered by universities. Miss Bridges is of the opinion that if a hospital maintains a school of nursing, the school should be financially independent and free to carry out its educational policies without reference to the demands of the nursing service. They agree that, if the teaching program is intelligently planned, it ought to be possible to prepare a student for any branch of nursing in a maximum period of four years.

It would be rash to suppose that there will not be strong opposition to these schemes and to the proposal that legal status be given to assistant nurses. Nevertheless, these new trends deserve careful study in Canada. We may have to face up to them sooner than we think.

—E. J.

Growth of the Soil

A. F. Menzies, M. D.

If the first decade after this war follows the same pattern as the decade in Europe after 1918, we in Canada may see the same mass hysteria and malnutrition of large numbers of our population as was observed in Europe during that period. Problems connected with malnutrition are present in peace time but are largely ignored. They are the weak points in the armour of modern civilization; the stress of war has brought them into prominence and the post-war period with its uncertainties and economic problems will only further accentuate them.

When we turn to nutrition we approach a subject which in recent years has received attention by animal husbandry men, dietitians, popular journals, and food manufacturers. Among animal husbandry men the study of nutrition is understood to be the study of soil, the study of plants used as animal food and the study of animals themselves. I propose to follow that outline, not that I hope to pass on any mass of new knowledge but rather in the hope that I may stimulate a desire to investigate a field of which we know very little. In Western Canada, before the prairies were broken up, the aspen bluffs cut down, or the oak grubbed out, the trees, shrubs, flowers and grasses had sorted themselves out into a pattern where each was either growing in a particular little area where the conditions of climate and soil were best suited to its continued existence, or plants with some particular resistance had occupied spots which the more fastidious trees and grasses had passed by. The native vegetation was used by primitive man and by early settlers as a guide in the choice of crop and grazing lands and is still used in reconnaissance surveys to indicate boundaries between soil types. It should be pointed out that top soil is the product of the influences of weather or weathering and vegetation upon primitive geological material, and of the three, vegetation may be the most important in determining the character of the final product. For example south and west of Winnipeg is an area in which you find no oak trees, no ash or no elm, they have never been there and if planted there would die. What you have are small aspen, a few varieties of willows and a grass peculiar to that area, plants which tolerate that high lime subsoil, and plants that require very little iron or phosphorus.

Just as the plant life in this western country was not distributed evenly over the whole country in accordance with its ability to produce but was distributed in a crazy quilt fashion, the wild animal life was similarly distributed. The distribution of animal life was probably dependent upon where it found vegetable life best suited to its needs, or else the animals through time, changed to reach a condition such that only plants of a certain area satisfied their needs. Why were antelope only found on the prairie south and west? There must be something in the vegetation or water of that area suited to their physiology or else their physiological processes had changed from remote ancestors to make them suitable to that area. Just as there was a characteristic native vegetation and wild animal life in this western prairie so there was a characteristic na-

tive human population distributed in tribes, each tribe with its own peculiar traditions and habits.

John Marrett advances the thesis that a natural selection of various food substances based on economy has played an important part in guiding the evolutionary process. The minerals and vitamins in food through their effect on the composition of body tissues and fluids, and on the glands controlling internal secretions, profoundly influence the internal environment of the body cells and thereby affect growth, physical form and emotional reaction.

Primitive man was restricted to the food supply immediately at hand. This supply was determined both in quality and quantity by the soil and climate. The kind of food availabble and its composition were important in determining survival and the differences in the physical development of men from different areas. That same restriction and variation in food supplies which produced clear-cut racial differences apparent to the eye also produced those deeply ingrained patterns which are the basis for the so-called natural instincts, sometimes referred to as guiding choice of food. For example, the use of Vitamin A rich pimiento in Mexico, the similarly rich vitamin A annato in Puerto Rico, and the eating of prairie dogs and fat field mice by the Indians of the southwest when meat was scarce.

Now what has happened in this western country in the last seventy years where the white race has invaded and taken over a country in which an equilibrium had been established between soil, plant life, roaming wild animal life and nomadic Indian tribes? The wild vegetation has been replaced by cultivated cereals, garden vegetables and cultivated grasses—with what effect? Domesticated animals, limited in range, have been fed those cultivated products—with what results? People with European background, the product of European soil and climate, have replaced the native Indians—with what consequences?

Work on relationships between soils and plants is proceeding in all parts of the world. Investigations in this field have led to remarkable discoveries in clearing up the causes of certain mysterious diseases of plants. Chlorosis of plum trees in South Africa has been found to be due to a deficiency of copper; dry rot of sugar beets and turnips, cracked stem of celery and internal core of apples to a deficiency of boron. Further, it has been shown that the requirements of certain elements are not the same for even closely related plants. Rye does not need as much nitrogen as wheat, and neither rye nor wheat need as much phosphorus as barley. And just as plants vary in their mineral requirements, they vary in their ability to concentrate in their stem and leaves some of the less common elements. Cabbage, turnips, and onions take up an unusual amount of selenium from the high selenium soils of South Dakota. This ability is quite pronounced in certain native plants and explains their avoidance by native animals. Finally, soils high in calcium carbonate may produce deficiency diseases owing to the fact that boron, iron, magnesium, phosphorus, and perhaps other elements are rendered relatively insoluble by that compound.

Work among domestic animals which exhibit signs of degeneration has been just as productive in discovering conditions due to mineral deficiency as the work with plants. Iodine deficiency is universal in western Canada, and in most of the known world. Iron deficiency in Florida, where cattle became anaemic if left to graze for more than six months on iron deficient sandy soil, has been avoidebd if the cattle are alternated each three or four months be-

tween pasture on clay soil and that on sand. The presence of selenium in soil, cereals and water, although it does not interfere with normal growth of hens, their egg production, or the fertility of their eggs, yet does produce constant deformities in the embryos resulting in the death of the young chick in the shell.

There are two points I should like to bring out with regard to these mineral deficiencies. First, in some cases these deficiencies were not apparent in virgin soil, they appeared after years of cultivation; some are most marked in obviously depleted soils, others, as cobalt, in the more productive soils. Second, the deficiency in some cases can be made good by feeding the soil with phosphorus or cobalt. In the case of iron deficiency, you must feed the plant or animal. Soil chemistry has been of limited value in the study of deficiency diseases of plants and animals .The final test has been feeding experiments, and geographical investigations or surveys.

Let us now leave the study of plants and domestic animals and consider medicine. In so far as a knowledge of or an interest in mineral requirements is concerned, the first impression is one of having passed from an atmosphere of enlightenment into darkest night. Let us examine the facts. Is man subject to the same laws of physiology as other animals? Are there signs pointing to mineral deficiency in human nutrition? Is our self-complacency justified or would we like to know more about man's mineral requirements? The oldest and most universal mineral deficiency in human diet is common salt. Neither of the elements sodium or chlorine are necessary for plant growth; nearly all vegetable growth is so deficient in both sodium and chlorine that both these elements must be taken with the food to create the hydrochloric acid in the stomach and to counterbalance the large excess of potassium ingested with the vegetable food. This problem was unconsciously solved by a physiological craving for salt in all but carnivorous animals and tribes who subsist on an exclusive meat diet.

The next deficiency which is almost universal is that of iodine, another element whose salts are extremely soluble and has been leached from the soil and rushed to the sea. The iodine problem is too well known to need further discussion except to point out that due to the fact that iodized salt has been available only in two pound cartons, probably 75% of the rural human population in Manitoba today is still using non-iodized salt.

In 1926, Dr. E. W. Montgomery gave a report on an investigation which was conducted upon pernicious anaemia, partly in the nature of a survey as to incidence and partly a laboratory investigation. He definitely reported a geographical distribution of pernicious anaemia in Manitoba, Saskatchewan, and Alberta. Most of the survey was made by correspondence but the worst of the Manitoba area (Carman, Miami, Manitou, Morden and Holland) was surveyed by Dr. Montgomery personally and included analysis of water from many wells. The water analyzed was all quite alkaline with high saline content. No estimation of the amounts of the less common elements was made. I have personally had water from one well in the area analyzed for estimation of selenium and fluorine. The well had a shale bottom, fluorine was present three parts to 1,000,000, selenium was absent. The family had white chalky spots in their teeth produced by fluorine and both children exhibited clinical signs of pituitary disturbance. Did the fluorine affect their pituitary glands? Does the water contain other toxic elements? I do not know, but would suggest that an

exhaustive analysis of water in that area might yield more information.

Within the area in which Dr. Montgomery reported pernicious anemia to be prevalent there is a township in which I know every man, woman and child. They are all Anglo-Saxon, fairly prosperous, and all under fifty years of age were born in the area. My experience with the district goes back twenty-one years. At present I have two men and two women under treatment for pernicious anemia. In 21 years there were no cases of leukaemia. In an area of similar size surrounding Winkler, Dr. Wiebe has seen, in fifteen years, one case of pernicious anemia, but in the last 24 months has had four deaths from myelogenous leukaemia. I see ten cases of pernicious anaemia to his one, while he sees ten cases of leukaemia to my one. Although there is almost no colloid goitre in the township. I have three mild myxoedemas and two cretins under two years of age under treatment at the present time.

On an almost adjoining farm are four men and one woman ranging in age from 25 to 50, with new bone formation around joints, three in the elbows, one in the knee, and one in the spine. They did not have the usual arthritic history. X-ray plates, taken when discomfort first appeared, showed that new bone formation was already present. A number of children from that area have been brought to the office because they were eating dirt, all of them stopped in one week when given bone-meal. Pregnant women with usual cravings and backache were all relieved by bone-meal. In that area I do not know any farmer who is successfully and economically raising pigs without giving a mineral supplement of bone-meal and iron. They were getting along well until about ten years ago but cannot now. I don't think we can escape the conviction that we have there an area of mineral deficiency and that all young animals including children should be getting a mineral supplement, the exact nature of that supplement I am not yet prepared to state. But the mineral deficiency is not the whole story, there is probably also a toxic element left either by the glacier deposit or receding waters of Lake Agassiz, the nature of which is yet to be determined.

We of the medical profession have been naturally blind, or to borrow an expression from Hendrik Van Loon "we have suffered from a shut mind". We have sat back and because such chemical analysis of food as we have show no deficiencies of common minerals, wisely affirm that there is nothing wrong. We fail to realize that due to modern processing two-thirds of our food supply has been deprived of almost all its vitamin content and minerals. All our minerals and vitamins must be supplied by that third of our food supply which is largely locally produced and, in the case of rural population, almost entirely so. It has been proven in regard to plants and domestic animals that not only must minerals be present in sufficient and correct amounts, but they must also be present in a utilizable form and in correct proportion. It is in disturbing the correct proportions that unsuitable well water produces its effects, producing an actual deficiency where according to chemistry and mathematics no deficiency should exist.

I should like to know the result of a survey of the children in Australia or New Zealand where the sheep had bush sickness. What is happening to the children in that county in Nova Scotia where they can't raise cattle, that country in Ontario where you have boron deficiency, that area in Manitoba where you can't raise cattle successfully because of phosphorus deficiency? But why

continue? The United States Department of Health is making an investigation to discover if the selenium soils in South Dakota are having any effect on human beings.

What is the solution? The medical profession of Canada has a responsibility and the people of Canada look to us for guidance. We must prepare ourselves to supply that guidance. It is possible that there is within the medical profession today a sufficient number of men qualified to speak with authority on the training of our children and youth. I doubt it. I am a little more hopeful that sufficient work is being done, particularly in Toronto, which will result in certain men being able to speak with authority upon how to produce, prepare and distribute food such as will supply an optimum supply of necessary vitamins, and that in part at least they will be able to prove their points by actual experiment. But as to mineral metabolism we can say little.

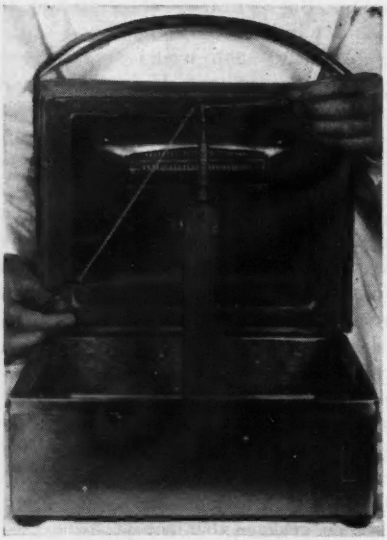
My suggestion would be that in at least some of the Universities there should be a chair of experimental medicine linked up with the Research Council of Canada. During the last fifteen years the medical profession has followed closely the work done with relation to the value of and necessity for certain vitamins. On the other hand we have almost completely ignored the work done on geographical distribution of degenerative diseases in domestic animals showing that certain degenerative conditions are due to mineral deficiency, and that others are due to the toxic effect of other minerals. Much work needs to be done but the investigation will not be undertaken until the medical profession realizes that the problem exists and demands action. The only insoluble problem is the problem that is ignored.

The Patient and Radiotherapy

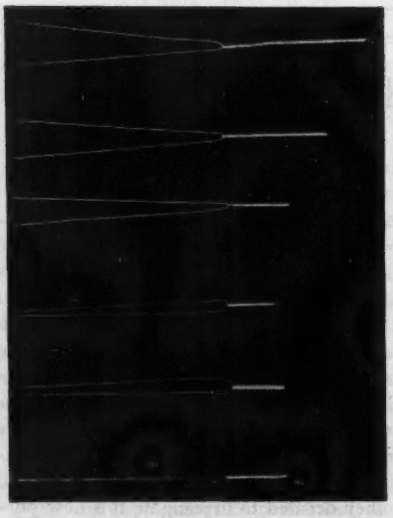
CLARIBEL MCCORQUODALE

Radiotherapy is the term used to designate the treatment of disease by means of x-rays, radium rays or any combination of these. It is important to remember that these are very similar physical agents and differ from each other only in wave-length.

The story of the discovery of x-rays was told in an article which appeared in the September issue of the *Journal*, but the discovery of radium is also a story of great human interest as well as being of scientific importance. Those who have read the life of Marie Curie, written by her daughter, will be familiar with this story which is briefly as follows. A French scientist, Becquerel, had carried a small quantity of uranium ore (pitchblende) in his waistcoat pocket and had suffered a sharp burn on his abdominal wall which was attributed to some type of unknown radiation given off by the ore. At this time Madame Curie and her husband, Professor Pierre Curie, were working in the physics department of the University of Paris and they decided to investigate this new phenomenon. The investigation occupied several years and is a story of almost unequalled courage and tenacity. Before it



Radium loading cabinet and procedure used in threading radium needles.



Radium needles and tubes ranging from 1 to 10 milligrams in radium content.

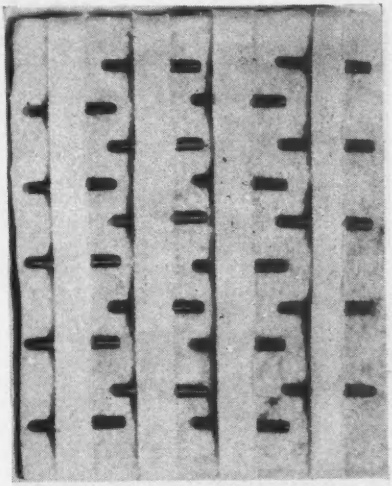
was completed, Professor Curie was killed under tragic circumstances and Madame Curie completed the work alone. The final result was the discovery that certain elements, which are now known as the radioactive group, were spontaneously giving off radiations and of these radium is the best known example. For this work, Madame Curie received the Nobel prize in physics and was acknowledged to be one of the world's great physicists. Within a fifteen-year period, Roentgen had discovered x-rays, Becquerel had discovered radioactivity, and the Curies had isolated radium.

It is now known that radium gives off three forms of radiation, alpha, beta and gamma rays, of which beta and gamma rays are used in treatment. Gamma rays are a form of radiant energy exactly similar to visible light and to x-rays but having a much shorter wave-length than either. When used for medical purposes, radium is prepared in the form of the bromide salt which is a yellowish brown insoluble powder. It is enclosed in various types of tubes and needles and made up in a great variety of strengths for greater convenience. Some of these, and the manner in which they are used, were demonstrated in the moving picture shown at the annual meeting of the Registered Nurses Association of Ontario. This picture showed demonstrations being given by the radium nurse.

In loading radium needles, the nurse stands behind a lead screen which is made of lead one inch thick. In order to prevent unnecessary handling of the radium during the process of threading the needles, they are placed in a vice which holds the needles firmly in position. A fine wire loop is passed through the eye, by means of which the thread is drawn back through, thus threading the needle. The accompanying illustrations

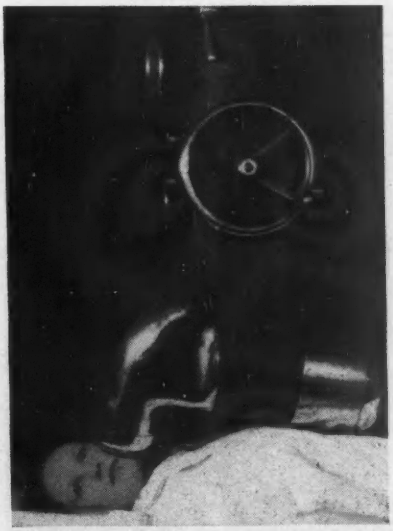
show the lead screen and the vice used for threading needles and also the various types of radium needles.

One of the more common forms in which radium is applied, in addition to its use in the form of needles, is an applicator called a radium pack, illustrated herewith. This is a method of applying a larger quantity of radium at a short distance from the skin. The distance commonly employed is one to three centimetres which is obtained by the use of felt of the desired thickness. The whole package is covered with waterproof material in order to ensure the cleanliness of the radium. This method of treatment is used in certain types of secondary carcinoma such as secondaries in breast cancer, secondary glands in the neck, carcinoma of the thyroid and other similar lesions close to the surface of the body.

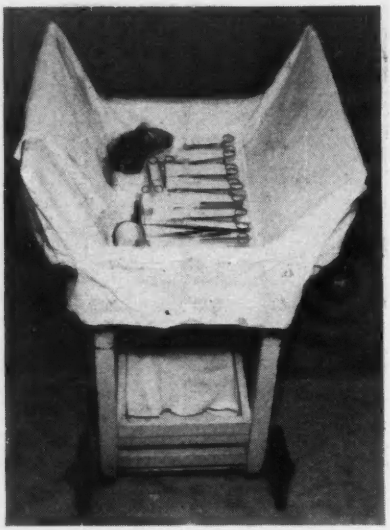


Platinum tube radium pack.

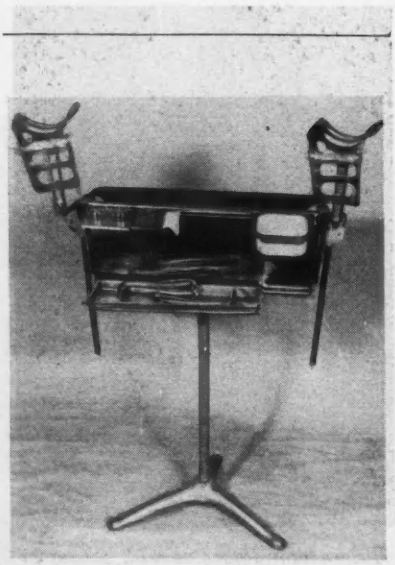
An elaboration of the principle of the radium pack is known as Teleradium therapy. The apparatus is designed to make use of a still larger quantity of radium than in the pack previously described. Quantities from four to five grammes are commonly employed and, in some cases, ten to fifteen. The name Teleradium therefore implies the use of a large quantity of radium at a distance from the body. The larger the quantity of radium the greater the distance at which it can be used, up to ten to fifteen centimetres. The apparatus is so designed as to permit obtaining any desired position. This quantity of radium provides a very powerful beam of pure gamma rays and in its use the utmost care and precaution must be practised by the nurse responsible for its use. The patient is first placed in position and the radium unit is inserted in the apparatus; the nurse then immediately leaves the room. In some institutions the radium unit is transported to and from the apparatus automatically thus



Teleradium apparatus with patient in position for treatment of cancer of the tongue.



Lead lined radium table with folding top.



Appliance used in the treatment of cancer of the cervix.

avoiding the necessity of the nurse handling the radium at all. The accompanying illustration shows the apparatus in use.

There are certain rules for handling radium which must be strictly observed. Among them are the following:

1. There is a separate container for each type of radium, therefore all tubes and needles not in use should be in the proper place in the safe.
2. Radium is handled with forceps at all times. There is no exception to this rule.
3. Since there are many different types of radium in use in the treatment work, it is usual not to have more than one type in the loading cabinet at one time. If it is necessary to have more than one type out, separate containers should be used.
4. As soon as radium has been removed from the patient it should be returned to the loading room, cleaned and put away without delay.
5. Radium removed from the safe should always be checked when removed and checked again when returned to the safe. The radium nurse is held responsible for this count and the count should be verified daily before going off duty. Any discrepancy should be reported at once.
6. When delivering radium to the operating theatre it should be signed for by the nurse in charge of the operating room to which it is delivered. Radium not used in the operating room is returned to the department and signed for by the radium nurse.

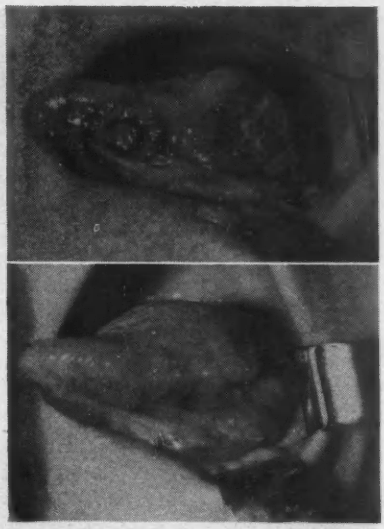
The cleansing of radium differs from that of surgical instruments in that when an operation has been finished the instruments which were used may be handled freely for the purpose of cleansing, whereas this is not possible with radium

owing to the danger from continuous exposure to radium rays. Special precautions have therefore to be adopted. The two chief considerations are that radium must be handled by forceps, never touched with the fingers, and kept at as great a distance as possible until it has been cleansed, sterilized and returned to the safe. All the established rules practised are based on the above principles.

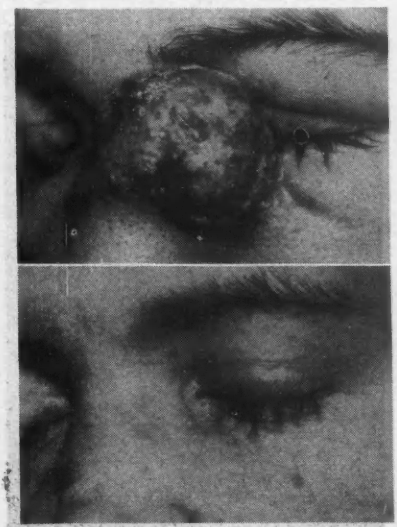
After removal, radium needles or tubes are placed in a 50% solution of hydrogen peroxide and allowed to stand in a cabinet protected with lead for five to ten minutes. They are then transferred by means of forceps to a beaker of sterile water, thus removing particles from the eye of the needle. The next step is a thorough cleansing in green soap and water. Following these procedures the radium is then sterilized by boiling for five minutes. When removed from the sterilizer it is polished by means of chloroform. The radium is now stored in the radium safe until it is again required.

In the moving picture, the preparation of trays was demonstrated by the assistant radium nurse. While the radium nurse is preparing radium for use during the day the assistant radium nurse prepares the trays which will be required for the various applications during the day. The film demonstrated the nurse preparing a patient for the insertion of radium needles in the lower lip for the treatment of an early carcinoma. The illustration shows the instruments necessary for such a treatment. The table is lined with lead and when not in use the folding top remains closed.

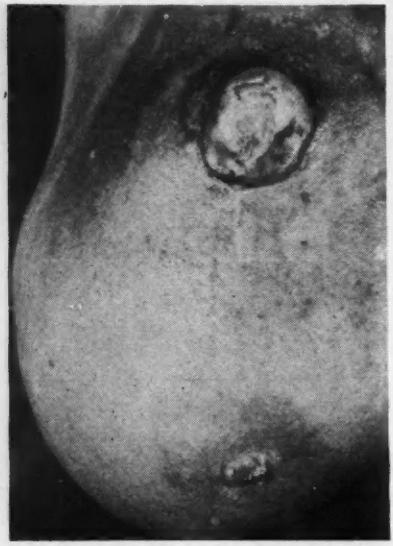
A demonstration followed which dealt with the preparation on the part of the nursing service in connection with the treatment of female genital carcinoma. A convenient appliance has been devised which may be attached to any



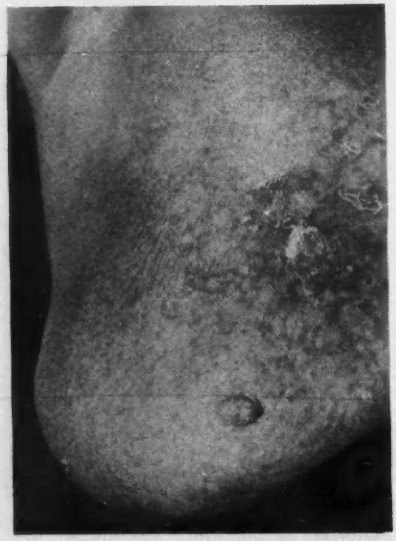
Cancer of the tongue before and after treatment by high voltage x-ray therapy.



Cancer of the inner canthus of the eye before and after treatment by radium therapy.



Inoperable cancer of the breast before treatment.



The same lesion following treatment by high voltage x-ray therapy.

operating or treatment table for use in the treatment of cancer of the cervix. This was developed by the director of the Department to simplify the examination and treatment of such cases. It is removable and may be adapted to any treatment or operating room table in which stirrups are used. When not in use it is removed and stored in a convenient place. The tray shown is a tray from a standard sterilizer simplifying resterilization of the instruments. Provision is made for the cleansing and sterilizing solutions and also for vaginal packing which is used in the form of a roll (a two-inch fine gauze bandage is used). The basin on the right is used for soiled sponges. The appliance is so constructed that any one part may be removed for the purpose of sterilizing.

In carcinoma of the tongue the treatments are given daily over a period of three weeks. At the completion of the treatments a marked skin reaction over the face and neck should develop resembling a severe sunburn, and should be treated by means of soothing applications of borated vaseline. The patient is advised to use a mouth wash of Dobell's solution hourly. Morning and evening, it is advisable to use a weak solution of hygeol in order to thoroughly cleanse the mouth. If there is any discomfort with mucus, it may be removed by using a hot solution of soda. Dissolve one dram of bicarbonate of soda in a glass of hot water and use it as a mouth wash as hot as can be tolerated with comfort. This will dissolve the mucus and if the mucus is excessive this should always be done before using the mouth washes recommended above. The accompanying illustrations show a case of cancer of the tongue before treatment by high voltage x-ray therapy. The same lesion is shown six weeks later, and the healing is seen to be complete. The tissues are usually soft and very normal with very little

scarring or interference with function.

The moving picture also demonstrated a very large inoperable carcinoma of the breast thought to be hopeless and therefore neglected. The treatment was by high voltage x-ray therapy. A severe reaction was produced and when it healed the carcinoma had disappeared. The accompanying illustration shows the result, and there has been no recurrence. The time which has elapsed since the completion of treatment is two years.

There is a belief that radium cannot be applied safely close to the eye. The fact is the eye tolerates radium rather well and some of the best results are obtained in this type of lesion. The treatment in this case shown in the illustration was by means of interstitial radium needles which were left in situ for four hours. Local anaesthetic was used and therefore it was not necessary for the patient to be admitted to hospital. Although the lesion was fairly extensive the resulting loss of tissue is not great and the cosmetic result is excellent.

In conclusion it is pointed out that the original presentation was in the form of a cinema in which the various subjects covered were accompanied by a commentary. In addition, a scientific exhibit was shown amplifying the subjects presented. It will be obvious that this method does not lend itself to reproduction in the form of a magazine article and it is hoped that the necessary allowance will be made since this presentation is intended to be merely a summary of the cinema and its commentary as presented at the annual meeting of the Registered Nurses Association of Ontario.

New Zealand Nursing Sisters in Greece

The hospital in Greece was grand. Our patients arrived quickly, not many wounded, but lots of other things: dysentery, pneumonia, scabies, measles, septic hands, appendicitis, injured knees. Some of the nursing sisters had 100 beds each and became very good at making things out of nothing. Kerosene was hard to get, so the water was boiled in tins outside on open fireplaces. We lived there very happily, going to bed at dark because of the blackout, bathing in icy cold water from the creek nearby, living on tinned foods, and not a complaint. We had no bombing in our locality, but we could hear the guns.

All too soon we began to realize that our position was not secure and on the night of Easter Monday the O.C. told me to rouse the staff and pack immediately what we could carry as we would be going on a train during the night. Two of us stumbled round the hillside and wakened the staff—all sound asleep, but there were no complaints, they just tumbled out of bed. At 2 a.m. we were told that we would not be moving until midday and to get some rest. It was a bitterly cold night so I curled up in blankets and tried to sleep, but a German plane and screaming bomb wakened me. A little later I was told that we would move immediately in the dental unit mobile trucks—and to hurry. Staff and luggage were piled in, counted and recounted to make sure that all of the 52 nurses were there. We travelled in convoy at ten miles an hour and suffered from extreme dust and truck sickness.

On arrival at Athens we lived in hotels for a few days, then moved on to Kafiosia. We were near an aerodrome and had our share of raids—the sirens

screamed all day long and we could see the dive bombing and machine gunning. The weather was perfect, lovely days and flowers everywhere, scarlet poppies and lilac trees. Everything so beautiful around us, but the atmosphere of war was very wearying. Orders came to move, as a hospital ship was taking us, but when we were ready we were told that only 32 could go, the 20 to remain for the next trip. After making the necessary arrangements, loud cheers greeted the news that after all we could all go together. We reached the port only to be told that because of the severity of the air raids the hospital ship was unable to wait for us because the risk for the wounded on board was too great. So we turned about and had to wait several days for our second orders. That journey was to be by train and when we were ready to start it was discovered that the line was dislocated so we spent the rest of the day hiding from bombs in a corn field. At 11 p.m. trucks arrived and the sisters were counted into them—just to be sure that no one was left asleeep in the corn field. We travelled all that night in convoy and were joined by English and Australian sisters. The pace was slow over the mountain pass and there were many stops and starts. We were in almost complete black-out, but there were cars behind with glaring headlights.

At day-break we halted for breakfast of bully beef, biscuits and a drink of water. Then there was a warning of planes approaching so we all jumped out of the trucks and lay flat in the fields. They droned over, bombing and machine gunning, but none of our party were hurt. Then word came that one of the trucks had skidded and gone over the side, we were almost too frightened to look. Fortunately it landed on its side, but the sisters got some nasty cracks. One by one they were lifted out and the casualties amounted to two severe concussions, a broken arm and other fractures. They were put into ambulances and we set on our way again. When the next raid came we left the convoy and spent the day in a graveyard and, as each lot of planes came over, we lay flat on our tummies; luckily we were not seen. The next day the grave yard was bombed to fragments. After nightfall we set off again for about seven miles and then all except the injured had to walk a mile in pitch blackness each carrying her own gear. We were told to walk quickly and quietly and not to stop. We reached the wharf and could see the outlines of a destroyer appearing out of the darkness. The Navy was wonderful and we were on board in a few minutes. Such a crowd of us. Hot tea was served all round and we slept under the guns and around the decks, in the ward rooms and in the cabins which the officers gave up.

For breakfast the navy turned on bacon and eggs for everyone; it was marvellous how they did it. During the morning, an air raid was attempted and it was a thrill for us to watch the manning of the action stations and the handling of the attack. To that destroyer we owe more than we can say—to the Navy we owe our lives. In the afternoon we arrived at Crete and were there for four days in an English hospital. We had a great welcome and after food and a night's sleep we spent four busy days receiving the men from Greece. We were ultimately taken off on a Greek ship surrounded by our magnificent Navy.

Editor's Note: This inspiring narrative was written by Matron Mackay, Number 1 General Hospital, serving with the New Zealand forces in Greece. It is reprinted from the July issue of *The New Zealand Nursing Journal*.

Bridget Writes Home

N. L. Burnette

Canadian nurses, particularly those in visiting services, are coming in contact with increasing numbers of British war guests, both child and adult. What do these sojourners in our midst really think of this country? Will the opening of our hearts and homes be reflected in letters to the old land? Will many of those who are here desire to stay? More important still, will they urge others to join them after the war?

There is an interesting historical background to this speculation. The strength and character of our Anglo-Celtic population is derived mainly from two post-war emigration movements: first, the Loyalists, and later, that which followed the close of the Napoleonic struggle. We know a great deal about the thoughts and experiences of these early settlers because they wrote a surprisingly large number of good books. Most of those who have left us their written comments were people of gentle birth. They wrote gracefully, and with an eye to the polished phrase. But not all. Fortunately, there has been preserved for us one gorgeous exception.

In the years 1831 and 1832, a Mr. T. W. Magrath described Upper Canada in a series of letters to the Reverend Mr. Radcliff of Dublin, Ireland. Influenced in part by the information contained therein, members of the Radcliff family, totalling in all thirteen persons, emigrated to the New World. The party brought with them a maid named Bridget, and Bridget, bless her heart! wrote home. In 1833, the Reverend Mr. Radcliff published "Authentic Letters from Upper Canada". The volume contains letters from Magrath, Mr. Radcliff's sons, William and Thomas, and a daughter-in-law. Mr. Radcliff placed posterity under a debt of gratitude by including some of Bridget's compositions.

Bridget's first letter is from York, Upper Canada:

> Dear Fellow-Servant and Fellow-School Fellow: (she writes) For we were edicated together, and prenticed out together — and my blessing on the committee of fifteen, and my blessing on them that taught us to read and write and spell, that you may know all about me, and I about you, though there are rivers, and seas, and woods, and lakes between us — and my blessing on the mistress that taught us to work, and wash, and make ourselves useful, so that while health stands by us, we may earn honest bread in any country. And sure enough, dear Mary, you shall hear all the good and bad that happens me.

An unusual opening, but it has a familiar ring. Let us see if we can trace the model. Many centuries before Bridget was born, one of the greatest stylists of all times wrote to his friend Timothy as follows:

> Let as many servants as are under the yoke count their own masters worthy of all honour . . . and they that have believing masters, let them not despise them because they are brethren, but rather do them service . . . these things teach and exhort.

Lacking proof to the contrary, one surmises that Bridget's model was not Lindley Murray's English, but King James' version English — and there is none better. Bridget's description of the start of the journey is too accurate to be funny:

> If you were only to have seen how smooth we floated down the river . . . you would have said, away you go — eating, and drinking, and laughing, and cracking jokes, but

my jewel, before the second day was over, we were all knocked of a heap and then if you were to hear all around you as I did groaning and raching and willy wombling . . . and wishing themselves at the bottom of the sea.

"Willy wombling" is a lovely term. It deserves to be rescued for present day use. However, the sea-sickness passed and soon Bridget is well enough to take an interest in her fellow travellers. In a few deft strokes she paints the situation in Ireland which was to give Ontario its deep Orange hue:

The hold was full of people, mighty snug and decent, with money in their pockets, going out to make their fortunes, and most of them Protestants that found home growing too hot for them; and that they had better save their four bones and their little earnings before it was too late, and sure enough, I believe they're right.

Nothing could be fairer than this! Bridget was more than a sportsman, she was able to form judgments divorced from prejudice:

There are mighty good people among them and mighty pretty girls that when they aren't sick sing psalms in the evening very beautiful and there is one Jenny Ferguson, from the north, that I am very thick with.

Of course there weren't only young women on board:

There are some gay lads and great fun and a little courting but all in a civil way . . . and believe you and I Mary, but don't say a word at all at all I think there's a servant-boy of a Mr. Jackson's, one Benson, that's throwing a sheep's eye at me but nothing *certain* barring a sly pinch here and there and other tender tokens that may end in smoke.

During the voyage there was the usual drama of birth and death at sea. Bridget's letter relates that:

The only accidence we had on the voyage was an old woman that died and a child born in the hold and a little girl choked with a potato . . . and the captain, long life to him, put the old woman decent in a coffin, saying that the sherks should have a mouth full of sawdust before they got at her old bones.

Bridget has so much more to say about the sea voyage, that there is neither time nor space to speak of the journey from Quebec to York. She promises to write again when they are settled:

And whatever comes across me there, Mary, you shall know the particulars of it, as it may be a temptation for you to come out yourself next year, with your own black eyes to throw yourself in the way of the same good fortune. They say no girl barring she is old and ugly, will stand two months.

Apparently Bridget had sized things up very quickly. Certainly her opinion was shared by others in a position to know. Doctor William Dunlop, agent for the Canada Company, wrote a valuable guide of emigrants ("Statistical Sketches of Upper Canada" by "A Backwoodsman," London 1832). In this book, Dr. Dunlop seriously advised persons of means "to import only women who could be described as perfect frights; "otherwise, he says, "if you bring out anything tolerably young or good-looking, she up and gets married on you in the course of the first two months of her sojourn."

Four months after their arrival in York, the Radcliffs were settled in Adelaide, west of London, and Bridget writes home again:

Dear Mary, To tell you all we had to bear since I wrote last would take a choir (quire of paper?) and in troth I have no great time on hand for sure enough I have *changed my situation.* Now I know what you'll say — oh! I knew what the tender whisper and the loving pinches abord the ship would come to — and I wish you joy *Mrs. Bridget Benson.* Troth then my dear, you're out in your guess — for it's no such thing, but *who knows?* Would you believe it he's living within four miles of me at Bear's Creek and comes over to church of a Sunday and to see me and to eat a bit

before he goes; and now Mary *the butter is coming out of the stirr-about* being that my change of situation is nothing more or less than my change from children's maid to *cook*.

A letter from Mrs. Radcliff, Jr., to her father-in-law throws light on this happening. In cholera ridden York, a baby girl was born. After an exhausting journey to Adelaide over roads that necessitated frequent stops for rest, Mrs. Radcliff was in such a weakened state that she was quite unable to undertake the labour of cooking for a family engaged in the heavy work of establishing a home in the bush. Bridget describes the trip westward:

And it's well that ever we got to this place (Adelaide) with them roads and the floods and the cricks and the axes going and the wagging knocked about and the horses tired, and the dark nights coming on us, and the mistress almost destroyed, and the children as bad. But God be praised, here we are all safe and sound.

The journey completed, Bridget, irrepressible as ever, exclaims in delight at her promotion:

I dressed a dish or two that pleased the master so she (Mrs. Radcliff) put me in the kitchen. I am now growing plump and fat (the cook's prerogative!) Benson tells me that I look better and better every time he comes over, and isn't it a great thing to be able to give a friend, and *such a friend*, a savouring toothful when he's so obliging as to go for to come so far to see you, and he a fine young lad that hasn't a nick in his horns yet, as the saying is, whatever he may live to have, and has the whole township to choose from. We've got a very good girl in my place (presumably to help with the children) a little Yankeeish as they say — but we must give and make allowances. I'd like her very well for a fellow-servant only she's always bothering me for *sa-ce*.

Friendly Indians paused to watch the settlers curiously. Magrath, in one of his letters to the Reverend Mr. Radcliff, speaks of a band that included a white woman, who, apparently had gone native. He surmises that for some Europeans, the fascination of the wandering life was so great that it overcame repugnance to dirt and discomfort. But you can't fool our Bridget. She cuts to the heart of the matter in crystal clear phraseology unencumbered by all impedimenta — including spelling: "I'd rather (she writes) die an old maid than be called a squawl and have a porpus tied on my back rolled up like a salmon in a hay-rope on the Wexford Coach". The final marvel was the maple sugar: "Mary, not a word of a lie do I tell you; you take a big gimlet and make a hole in the tree and out comes the sugar like sweet water, and you boil it — but where's the use of my telling you anything about it as you have no sugar trees at home!"

Indians were not the only denizens of the wild that visited the clearings. For the first fortnight, Bridget tells us she could not sleep because of the wolves "yowling and growling and yelling and pell-melling". Fifteen years ago, there were still living in the vicinity of Adelaide, old people who could vouch for the truthfulness of Bridget's description.

What became of Bridget? We do not know. The writer of this brief sketch is familiar with Adelaide and the surrounding country. He has talked to people, who as small children, remember the Magraths. But of Bridget, alas, there is no trace. Did her culinary attack on Benson achieve victory, or was the competition of the Township too much for even Bridget's stout heart? Whoever she eventually did marry was a lucky man.

Bridget's letters are her character reference. She faced up to life with laughter and high courage. In her, is embodied the indomitable spirit of Ontario's pioneers. Out of the forest, they carved the smiling land we know. This is their monument.

The Five Rites

JEAN M. DRUMMOND

In paying tribute to the memory of Sir Frederick Banting a speaker recalled the ringing words of Winston Churchill — "never was so much owed by so many to so few" and added that never had so many been consciously aware of the debt they owed to just one or two. Day by day, year by year, scientists labour faithfully to discover medicines that prolong life and alleviate suffering. "Medicine is as old as the human race, as old as the necessity for the removal of disease." Doctors order all medication, and once an order is written it is the nurse's duty to see that it is carried out according to the five "rites" — the *right* amount of the *right* drug in the *right* manner to the *right* person at the *right* time.

Intelligent and trustworthy nurses should know (1) source of drug; (2) properties; (3) action; (4) effect (toward and untoward); (5) toxicology; (6) methods of administration.

During our materia medica course at the Vancouver General Hospital we were asked to pick out thirteen commonly used drugs and write reports on them. Nurses being practical people, with no time for superstitions, we selected thirteen patients who were being treated on the medical wards and went to work. At the top of the page went the names of the patient and the doctor, and the date of admission, followed by the name of the drug and the date on which it was started. Then came the amount of the dose administered to the patient, as well as the average dose. Next, we explained why it was given, and the results obtained and expected. The methods of administration were described and a paragraph was added on the nursing care. The toxicology and the other uses of the drug were indicated and our report was finished. The association of the drugs with actual patients proved invaluable.

Brief mention will now be made of some of the newer drugs which are used in treatment of disease. *Sulphanilamide* is now familiar to all for its marvellous ability to cope with haemolytic streptococcic infections. In certain cases the direct instillation of this drug into the renal pelvis is valuable, while in cases of compound fractures splendid results have followed the packing of the wound with sulphanilamide crystals.

Sulphapyradine has proved to be the arch enemy of pneumococcal infections. Pneumococcus meningitis, once almost invariably fatal, now yields to the magic power of sulphapyradine (Dagenan). Mortality in meningitis has been reduced from 97% to 35% and the dreaded gas gangrene is less destruc-the sputum should be typed, and blood tive with the administration of sulphacompounds. Before Dagenan is given cultures should be taken before treatment is commenced. A red and white cell count, hemoglobin, differential white cell count, and urinalysis should be done. Check the Dagenan concentration frequently. Nausea and vomiting are frequent complications and it is important to record them as the patient may not be retaining sufficient medication. Soludagenan is given either intravenously or intramuscularly. Grave results, such as thrombosis, may follow if this is given carelessly. The toxic symptoms are haemolytic anemia, hematuria, and drug rashes. Cyanosis and central nervous

system disturbances may be noted.

Sulphathiazole is used especially in infections due to the staphylococcus and in pneumococcal pneumonia. Urinary tract infections have also been successfully treated. Used in bath-soap it has been used to control impetigo in the nursery. If given carelessly, this drug, too, may cause severe toxic reaction and irreparable damage. Here, as in Dagenan, daily blood work and urinalyses should be done. Nasal atomizers containing sulphathiazole are being used in some London air-raid shelters, not to prevent colds but to lessen the severity of the ailment. As the drug does not readily penetrate spinal fluid it is contraindicated in meningitis. The toxic reactions are similar to those of sulphapyradine. In administering this drug do not omit a dose or give irregularly as this interferes with the therapeutic effect.

A new compound—*Sulphanilguanadine* (may the trade name be shorter!) has been found to be effective in diseases of the digestive organs. Unlike the other "sulpha" drugs, it seeps slowly through the intestinal walls, remaining there long enough to affect the causative agents of typhoid fever, dysentery and other ailments. It is also believed that it may be of aid in surgery involving the alimentary tract.

Regarding the action of these magical pills, it is believed that they do not kill germs but that they merely slow up their action and allow the natural resistance of the body a chance to work. As one doctor has said: "The drugs simply hold the villain's arms while the body makes short shrift of him". To use a popular phrase of today, the body might say, "Give us the tools and we will finish the job". But above all remember that in the right hands these drugs may work miracles—in the wrong hands they may ruin health!

Benzedrine Sulphate has a stimulating effect on abnormal mental states. It is used to control lethargic and apathetic conditions and to combat sleepiness. As it is habit-forming, care should be exercised in administration. It is of interest to note that German soldiers have been given this drug in their campaigns.

Dilantin, while not a specific, has a definite place in the treatment of epilepsy, especially in seizures of the grand mal type. It neither prevents nor controls the progress of the disease but merely controls the seizures. It is usually given in gradually increasing doses and has the advantage of having a less hypnotic effect than phenobarbital.

Dettol is a bright blue, non-poisonous, non-staining antiseptic and has effective, penetrating powers and remains stable in the presence of blood and pus. It makes an excellent emergency preparation; the skin treated with it remains insusceptible to the haemolytic streptococcus for at least two hours.

Ethyl Alcohol has been injected into the necks of angina patients, blocking the nerve centres, controlling the spasms, and giving relief from pain for from one week to six months in a certain proportion of all cases. It has also been used recently in cases of a perforated appendix; 250 c.c. of 70% alcohol is poured into the incision and then drained off. The sterilized tissues make the removal of the appendix fairly safe, greatly lessening the danger of peritonitis.

Blood Plasma is not classified as a drug but it is interesting to note that dried plasma, having all the properties of red blood, will keep indefinitely in hermetically sealed containers, eliminates the need for typing, and can be used in isolated places where refrigeration facilities are lacking.

Heparin is an anti-clotting liver ex-

tract, recently produced in a highly purified form, may reduce the surgical death rate in operations where large blood vessels are involved. Recent experiments with animals have proved that heparin prevents adhesions when introduced into the peritoneal cavity.

Liver Extract has been used in treating ulcerative colitis with satisfactory results. Success is attributed to the Vitamin B complex which would increase resistance of the mucosa to infection and lessen sensitivity to foreign protein.

Everything is "vitamized" these days — our very tooth paste contains some of the best vitamins. *Vitamin K*, discovered in 1935, has been established as important in the clotting of human blood. Now it is valuable in saving babies threatened with internal bleeding and patients stricken with obstructive jaundice. Bile is necessary for the absorption of Vitamin K and is usually given with some form of bile salts as *Dessicol* (dried bile). Bile may be lacking in quality as well as quantity — in either case the use of Dessicol has proven to be efficacious. Concentrated *Viosterol* (Vitamin D) has been used in the treatment of psoriasis with resulting involution of lesions. Wheat germ, excepting yeast, is the best source of Vitamin G. Manufacturers, mistaking the whiteness of bread for purity rather than poverty of content, discarded the valuable bran, but now a vitamin-conscious public demands and gets its bread with the healthful vitamin content. Britain fortified her bread as well as her island in the hope of improving war torn nerves. Vitamin B, too, has joined the "Win the War" effort. Vitamin B complex has a marked effect on the growth and development of premature infants. Brilliant research work made possible the resolution of the Vitamin B thiamine, riboflavin and nicotinic acid. *Haliborange*, more readily tolerated than cod liver oil, is an excellent addition to the baby's diet, or as a precautionary measure against rickets and scurvy.

Pellagra was known in Spain as early as 1735 but not until 1914 did scientists determine that it was a dietary rather than a communicable disease. *Nicotinic acid* has been found invaluable in fighting this disease which lowers the resistance so dreadfully. Pellagra victims, sick, weary, forgetful, nervous and tired of living are given a few doses of nicotinic acid and rapidly begin their amazing restoration to health and happiness. Another use is in the treatment of delirium tremens and also in dealing with conditions in which an increased blood supply to the extremities is desired.

And now it is time to lock the medicine cupboard doors, and behind locked doors is where these drugs belong. Too many people are buying proprietary drugs only to find, too late, that their conditions require vastly different treatment. As nurses, it is our duty to warn the public today, tomorrow and forever, that it is both foolish and dangerous to make its own diagnosis and write its own prescriptions. We should stop now and then to recall the rose-scented night of graduation when with a deep sense of dedication to service we pledged "with loyalty will I endeavour to aid the physician in his work and devote myself to the welfare of those committed to my care".

Notes From the National Office

Contributed by JEAN S. WILSON,
Executive Secretary, The Canadian Nurses Association

Eulogium

The President of the Canadian Nurses Association, Miss Grace M. Fairley, called an emergency meeting of a sub-committee of the Executive Committee for August 15, 1941.

Before proceeding with business matters, tribute was made to the late Miss Jean Isabel Gunn in the following resolution, a copy of which was sent to Miss Gunn's relatives, to Miss Helen Locke and to the Board of Governors of the Toronto General Hospital:

That on the permanent files of the Canadian Nurses Association there be recorded the affection and indebtedness of the members to the late Jean Isabel Gunn, O.B.E., LL.D., for her great contribution to Nursing in Canada, and their consciousness of her influence in international nursing affairs.

Also Miss Gunn's memory is eulogized in the Minutes in the ensuing paragraph:

Her generosity and professional interest in individual nurses, whether from Canada or other countries has been known to many, with the result that her great example will ever be a tribute to her memory. The Canadian Nurses Association, over a period of twenty-eight years, received from Miss Gunn advice and guidance on almost every phase of Nursing and the problems of the Association. As Honorary Secretary and later as President, she gave willingly and generously of her time and experience, and her passing is an irreparable loss to the Association.

General Meeting 1942

The twenty-first general meeting of the Canadian Nurses Association will be held in the City of Montreal, June 19-27, 1942. The days of June 19, 20 and 27 will be reserved for meetings of the Executive Committee, thus leaving from Monday to Friday, June 22-26, for general sessions.

In spite of the decision to hold an Executive Meeting on June 19 and 20, the programme for the general meeting will have to be carefully arranged so that there will be ample time for discussion of the responsibilities of organized nursing in Canada, present and future. The programme committee have these needs in mind. No time should be lost by the Provincial Associations toward directing their district or branch organizations to arranging discussion programmes on such topics as (1) further preparedness to meet the demands of the present national emergency; (2) the safe-guarding of nursing standards and their adaptation toward whatever the future may require from the nurses of Canada; (3) special preparation of nurses so that they will be in readiness to meet future demands. Already these subjects have received serious consideration by the national and provincial associations, but the satisfactory promotion of plans by which effective action can be secured demands the interested support of every Canadian nurse. A well informed representation from each Provincial Association will make the general meeting in 1942 an epoch in the history of organized nursing in Canada.

Then, too, the visiting nurses will be privileged to join with the nurses of the Province of Quebec in observing the tercentenary celebration of the arrival of

Jeanne Mance in Canada. Arrangement of the celebration ceremonies will be under the capable direction of the Rev. Mother Allard, Superior of the Community of Hotel Dieu of St. Joseph.

It is hoped that those nurses who have been looking forward to visiting the city of Montreal will now resolve to do so in 1942 at the time of the C.N.A. general meeting. One of the best ways by which members of the Provincial Associations can show their appreciation in support of the officers of the Canadian Nurses Association during these unprecedented difficult years is to attend the general meeting that is held once in each two years. The Windsor Hotel has been selected as convention headquarters. This hotel has excellent space for such a meeting and provides accommodation for guests at reasonable rates.

British Nurses Relief Fund

When the Canadian Nurses Association established the British Nurses Relief Fund early in the present year, advice was sought from the Director of Voluntary Services of the Department of National War Services as to the need of the Fund being registered under the War Charities Act 1939. At that time it was anticipated that collection of donations to the Fund would be limited to nurses affiliated with the C.N.A., consequently the Association was advised that registration under the War Charities Act was not necessary. However, later on as it was learned there were nurses, especially in the married or retired ranks, who wish to contribute to the Fund, application for registration under the War Charities Act was made and a certificate of registration secured from the Federal Authorities.

In compliance with the Act, the C.N.A. appointed three members as a Committee on Administration for the "Canadian Nurses Association—British Nurses Relief Fund", namely Miss G. M. Fairley (President), Miss A. J. MacMaster (Honorary Treasurer), and the Executive Secretary. Each Provincial Association, regarded in the Act as a branch of the C.N.A., has been required to appoint a committee to administer the collection of their respective branch fund. According to the Act, all these appointments which have been approved by the Department of National War Services are permanent until the Fund is terminated.

In future, groups of nurses before undertaking by joint effort of any kind to raise donations for the Fund should secure authorization in writing from their provincial committee on administration, the personnel of which can be obtained from the provincial secretary.

Contributions to the British Nurses Relief Fund have been received from:

British Columbia:

Nurses of British Columbia	$200.00

Nova Scotia:

Branches, Registered Nurses Association of Nova Scotia:

Antigonish—Guysboro-Inverness and Richmond Branch	$6.00
Colchester County Branch	16.00
Cape Breton & Victoria Branch	36.75
Lunenburg County Branch	18.00
Halifax Branch	50.50
Pictou County Branch	28.40
Miss Killmaster, Canso	5.00

Ontario:

District 1: Graduate Nurses, Hotel Dieu Hospital, Windsor	$50.00
Districts 2 and 3: Nurses of Districts 2 and 3	100.00
District 5:	
A.A., Soldiers Memorial Hospital, Orillia	18.66
A.A., Toronto East General Hospital	50.00
A.A., Toronto General Hospital	150.00
A.A., Wellesley Hospital, Toronto	7.38
Toronto Branch, Victorian Order of Nurses for Canada	19.00

Toronto Department of Health, Public Health Nurses Association	4.00
District 7: A.A., Kingston General Hospital	140.00
District 9: Gravenhurst Chapter	135.00

National Defence Tax

The Income Tax Division of the Department of National Revenue has issued a brochure of information on the National Defence Tax as revised in July 1941. This pamphlet contains information for guidance in application of the National Defence Tax. It seems advisable to suggest that nurses study this pamphlet, probably by having a well informed speaker explain application of the National Defence Tax to Alumnae and other local organizations of nurses. One ruling (No. 34, page 13) is quoted for information of nurses: "That the remuneration of nurses paid daily, weekly, monthly, etc. is subject to tax deduction at the source".

Also any private duty nurses or others on irregular salaries who have not yet made the required returns to the Federal Authorities are advised to consult their local Income Tax Inspector without delay.

Nightingale Memorial Fund

Contributions to the Florence Nightingale Memorial Fund have been received from:

British Columbia:

Graduate Nurses Association, Fernie	$4.50
Student Nurses Governing Body, Royal Jubilee Hospital, Victoria	2.50

Flora Elizabeth Strumm

Flora Elizabeth Strumm died on September 17, 1941, at the Montreal General Hospital where for twenty-six years she had rendered outstanding service as assistant superintendent of nurses. At the time of her retirement in June of this year, affectionate tribute was paid to her by the Governors and Medical Staff of the Hospital, the Alumnae Association of the School of Nursing, and by all who were associated with her in her work. Miss Strumm was born and educated in the Maritime Provinces and received her professional training at the Montreal General Hospital while Miss Livingston was superintendent of nurses. During the thirty years that she was associated with the Hospital she became a living link between the old and the new and united in her own personality the best characteristics of both. A full outline of her useful and noble career may be found in the August issue of this *Journal*.

FLORA E. STRUMM

Canadian Nurses for South Africa

Eighty Canadian registered nurses recruited through military districts, and representative of every province, will make up the first group of the 300 requested by the South African Government for military nursing service in that Dominion.

From Alberta are: Jacqueline Brown, Paradise Valley; Margaret Josephine Dobson, Edson; Elsie M. Smith, Calgary; Katherine Feisel, Calgary; May MacDonald, Turner Valley; Emily Mayhew, Edmonton; Jean McIntosh, Margaret Carpenter and Mildred Marion Wright, Calgary.

British Columbia: Margaret Elizabeth Verey, Okanagan Landing; Mavis Thompson, Nanaimo; Margaret Grant and Julie deLotbiniere Harwood, Vancouver; Zoe W. Harman, Victoria; Muriel Ahier, Vernon; Ellen Kathleen Meagher, Victoria; Marguerite Cusson, Nanaimo.

Manitoba: Oglo Wicks and Nita McLardy, Winnipeg; Margaret Nuir, Elphinstone; Marie Angela LaCroix, Winnipeg; Grace Govenlock, Shoal Lake; Agnes Maloney, Deer Lodge; Frejya Olafson, Selkirk; Anne Stockwell, Killarney; Margaret Waugh, St. James; Jeanette Bernice Rusenel, Winnipeg.

New Brunswick: Fern Townsend, Fairville; Edith Cavell Lewis, Saint John; Laura Estelle McCluskey, Grand Falls; Marian McCafee, Saint John; Marion O'Neill, Saint John; Ina Wetmore, Clifton, King's County; Eleanor Ball, Newcastle; Dorothy Brown, Saint John; Annie L. Cullen, Chipman; Helen Beatrice Stephenson, Coldbrook; Annie Brewer, North Devon.

Nova Scotia: Margaret Blanche Germain, Caledonia; Nora Agnes MacNeil, Glace Bay; Florence E. Merlin, Springhill; Annie Maurren Green, Sydney; Margaret Goldsmith, Acaciaville, Digby County; Mary Agnes O'Brien, Westville.

Ontario: Nona Mannix, St. Thomas; Helen Winnifred Peer, Woodstock; Ida Marie White, Goderich; Edith Lovegrove and Alma Edith Patterson, Listowel; Mildred O'Leary, Toronto; Violet Parker, Port Arthur; Helen Fitzgerald and Edna Sullivan, Belleville; Mary Edmondson, Caledonia; Ella McMillan, Ottawa; Alice Josephine Monteith, Stratford; Dorothy Isabel Hayes, Byron, (formerly of Shawville, Que.); Marjorie Parker, Dresden; Phyllis Madeline Steinhoff, St. Thomas; Jean Lillian Barned, London.

Prince Edward Island: Dorothy Ruth MacWade, Charlottetown; Ethel B. Butler, Murray River.

Quebec: Marie Louise Eager, Kinnear's Mills, Megantic; Annie Edythe Ward and Isabel Lamplough, Montreal; Barbara Lapierre, Ville Lasalle; Julia Andrews, Megantic.

Saskatchewan: Kathleen Marie King, Boissevain; Emily Schmidt, Lipton; Christine Macdonald, Wapella; Isabelle Elizabeth Langstaff, Yorkton; Charlotte Cook, Regina; Orrica J. Smith, Semans; Germaine Quilichini, Biggar; Phillipina Schwab, North Battleford; Mabel Lang, Watrous; Helen Fountain, Strasbourg.

M.L.I.C. Nursing Service

Miss Olive Carrier (St. Mary's Hospital, Montreal, 1937) was permanently appointed on August 15, 1941, as a Metropolitan nurse on the Frontenac Staff, Montreal.

Miss Eugenie Tremblay (Notre Dame Hospital, Montreal, 1927, and University of Montreal public health nursing course, 1932) was transferred on August 25, 1941, from the Quebec City Staff to take over the Metropolitan nursing in Rivière du Loup.

Miss Marie B. Forget (Hôpital de la Misericorde, Montreal, 1924), Metropolitan nurse in Three Rivers, P.Q., resigned from the Company's service on September 14, 1941.

Miss Germaine Doyon (Normand Cross Hospital, Three Rivers, 1929, and University of Montreal public health nursing course, 1931) joined the Quebec Nursing Staff on September 22, 1941. Formerly Miss Doyon was in charge of the Metropolitan Nursing Service in Rivière du Loup.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association.

Nova Scotia Carries On

HAZEL R. C. MACDONALD

Within the past year, the mainland of Nova Scotia has been divided into four district Health Units, Cape Breton Island on the east coast having been organized as a Unit in 1937. All Units are under the supervision of the Department of Public Health of the Province of Nova Scotia. Each Unit is in charge of a specially trained divisional medical health officer. Each has a staff of public health nurses which we hope to increase until the desired number for efficiency has been reached. There is a central office for each Unit with one or more clerks and in the Cape Breton Unit a full-time sanitary inspector is employed.

Each Health Unit is equipped with a portable X-ray which can be used in any district where there is an alternating current of 110 volts, 60 kilocycles. There is a modernly equipped dental trailer working throughout the Province with a full-time dentist in charge assisted by a public health nurse. A provincial psychiatrist and a psychologist visit the different districts periodically and likewise a provincial sanitary engineer. Organization of our Province into Units such as these will enable public health work throughout the Province to become standardized. In his annual report for 1940, our Chief Health Officer has said: "It shall be our endeavour in this way to create an understanding and co-operation between lay persons, the physicians and the public health services". At the present time, on the mainland of Nova Scotia, there are approximately 700 beds for the care of the tuberculous, plus 138 in Cape Breton Island. Tuberculosis Units, in connection with general hospitals, provide the beds in Cape Breton.

The public health nursing service offered is a generalized one. There is a superintendent of nurses in charge of the entire nursing program for the Province and, in the Cape Breton Island Health Unit, there is a supervisor of nurses. The service covers both urban and rural districts.

Included in our generalized nursing program are the following:

Health education.

Prenatal and infant welfare. In the rural districts our nurses attend confinements and give postnatal care.

School inspections with triplicate reports going to family physician and parents and nurse.

Tuberculosis work, including home visiting and clinic service.

Assisting with immunization programs, the main work being done by the medical health officers and general practitioners in the different districts.

Keeping accurate records.

Bedside care in emergency cases and for the purpose of demonstration.

As tuberculosis is still a major problem in Nova Scotia, and as our most concentrated efforts are being put forth in helping to control this disease, it is with nursing in our tuberculosis control program that this article chiefly deals. The part the public health nurse plays in the following program is paramount:

Follow-up of known cases of tuberculosis.

Arranging for examination of all contatcs of known cases of tuberculosis.

Arranging for routine re-examination of cases and contacts.

Arranging for X-ray and fluoroscopic examination of all positive tuberculin reactors.

Arranging when necessary for the disposal of open cases and those patients requiring institutional treatment in Units or sanatoria.

Regular visits to the homes of tuberculous patients following treatment in sanatoria.

Routine visits to families in which case of tuberculosis has been diagnosed for the first time for the purpose of supervision of the health of the contacts and education of the patient and the members of his family.

Besides home visiting in relation to our tuberculosis cases, contacts and our clinic service, we have a definite case-finding program which includes:

Those persons referred by the family physician.

Our office receives duplicates of chest X-ray interpretations from hospitals served by radiologists. Those hospitals without such service, forward chest films for interpretation. All cases diagnosed as tuberculous are reported in our register.

X-ray or fluoroscopic examination of positive tuberculin reactors among familial and extra-familial contacts of known cases.

Persons referred by welfare organizations.

Tuberculin surveys of groups in the general population.

Our patients come from every walk of life, rich and poor, every class, creed and colour. We deal with the very young and the very old and we are particularly interested in the young adult group. Of late the over-sixty age group has been receiving more attention.

All service offered is free, but patients must be referred to our clinics. In urban centres clinics are held monthly at local hospitals, the space and facilities of the hospital being placed at our disposal. Clinics are held every six months in the surrounding towns and rural districts. In rural sections, church halls are frequently used but it just depends in which district clinic is being held as to the accommodation we have. In one place, we use a small building located in a gravel quarry and not far from that, we use a building at our National Park; then again, a convent is used and, in another place, the County Court House or Town Hall. In still another, we use a dance hall. Sufficient space has to be available, in addition to a waiting room, for the following: doctor's examining room (including space for the portable X-ray); space for interviewing nurse; dressing room; dark room.

The nurse in whose district the clinic is to be held notifies central office when she has sufficient patients and contacts listed to warrant holding a clinic. In this way, the number of days required is gauged for that district. The nurse in whose district the clinic is being held is responsible for securing accommodation; notification of patients; all supplies required for the general running of the clinic; arranging if necessary for transportation for patients.

We believe that a clinic runs more smoothly if there are two nurses attending; it is essential now in the Cape Breton Unit, as a nurse assists with the X-rays. Student nurses are asked to observe and assist at hospital clinics. We try to observe in arranging a clinic to have the patients from different sections

come in groups. Likewise, we arrange patients for first examination, for re-examination and those for fluoroscopic examination in groups. This facilitates the smooth running of a clinic.

The family is observed as a Unit and all contacts are tuberculin tested before clinic. Vollmer's patch tuberculin test is used. Only positive tuberculin reactors attend clinic unless advised by their doctor to do so. Negative reactors are re-tested yearly after the age of twelve. Positive reactors under twelve years have a fluoroscopic examination, those over twelve, are X-rayed. All contacts, whether familial or extra-familial are tuberculin tested and brought in for X-ray examination as soon after finding a new case of tuberculosis as possible.

Various methods are used for the notification of patients—in both urban and rural centres by telephone, printed notifications are distributed by mail, and through home visits. In some rural districts, church anouncements are still made, but with health education going on the people have learned who should or should not attend a chest clinic. A definite time is stated for each patient. Patients arrive at nine a.m. and continue to come until four p.m. For a full day we notify 40 patients. We start our rural Spring clinics in May, running through until August. Fall clinics start in October and continue until December.

Patients reporting for the first time, who have been referred by a family physician, have a first examination card record made out. Those coming for re-checks have a re-examination card and a special card is used for the contacts. Tuberculin records for each family surveyed and examined are handed in at the close of the clinic. As we use the family folder system of records, the nurse has a complete roster of cases and contacts at her disposal. The clinic card is a medical record and is filed in the Central Office. Through the use of the family folder the nurse has a picture of her community problems both in tuberculosis and in other respects.

Following the clinic a report on each patient is sent to the family physician and to the district nurse. They also receive from the Provincial Laboratory in Halifax, reports of all sputum examinations. Each nurse also receives regularly a list of admissions and discharges to and from tuberculosis institutions and a list of the deaths that occur in her district. In this way the nurse is kept informed of the progress her patients are making. The patient receives his report from his family physician unless an arrangement has been made between nurse and doctor for nurse to give patient his report. Usually two weeks elapse before reports are out. Follow-up visits to the homes are then made and arrangements completed for patients to enter sanatoria or tuberculosis units if necessary.

We wish every tuberculosis patient could have the opportunity of spending at least three months in a hospital; the educational value of such an experience is very definite. If a patient can, he pays his own way. If he cannot he is not neglected. The literature we use is that published by the Canadian Tuberculosis Association. We do not overburden our patients with pamphlets but we see that they have those that will be most helpful. We also have a literature display at clinic.

The greater responsibility for all clinics is borne by the nurse. She has to have everything in readiness for the arrival of the D.M.H.O. A well organized and conducted clinic is what we strive for, with sufficient time to talk to our patients to make them realize we are definitely interested in their welfare. In doing tuberculosis work the patient is not the only one who learns, for the

nurse learns from the patient. It seems to be that persons who have or have had tuberculosis develop a very definite philosophy of life. From them we learn the meaning of the words "spirit" and "courage".

With our present system of case-finding and because of our close co-operation with the medical profession and people plus an increase in our public health nursing staff to help carry out our program, we know that we will have tuberculosis under control in Nova Scotia in the not too distant future.

Public Health Nursing in a Rural Health Unit

KAYE MACNEIL

What is known as the "North Country" to the nurses of the Cape Breton Island Health Unit covers about sixty miles of isolated territory in Northern Cape Breton. The County of Victoria is served by two nurses, the districts are topographically divided by a huge mountain, "Smoky", so called because of its dark misty appearance. It stretches out into the ocean and in winter time completely isolates the northern territory. The scenery is reminiscent of the Highlands of Scotland. The hills, mounted against the everchanging background of the ocean, have a solitary grandeur peculiar to itself.

Along the coast are five little settlements each separated by hilly mountainous country. The inhabitants mainly are families of Scottish, Irish or Acadian ancestry. For generations these people have earned their substance from the sea or from small farming operations carried on in the vicinity. To a great extent they have retained their native languages. District nursing is done on a generalized basis and as much as possible in co-operation with the doctor there, but during the winter months the nurse very often has to rely on her own resources. Travelling is very difficult at this time of the year as there is a great deal of snow and navigation closes early. The only means then of transportation is by horse and sleigh, snow shoes, and sometimes by dog sled.

There are fifteen small schools which is a very small number compared with the other districts in the Unit. Full inspection of the school children is done once a year and rapid inspections of heads, skin and teeth several times as the nurse finds necessary. The local doctor holds school immunization clinics. The nurse plans and makes all necessary arrangements. Permission slips are first signed by the parents and an accurate record is kept for each child. A red card is used for scarlet fever toxin, yellow for diphtheria toxoid, and green for whooping cough vaccine. This school work is usually carried on in the spring and fall.

The tuberculosis patient is never lost sight of by the nurse and is visited many times during the year. The clinics are really the most interesting part of the tuberculosis work. These clinics are held twice a year, when the Divisional Medical Health Officer visits the district with the portable X-ray. Unfortunately the X-ray cannot be set up in each

settlement due to the absence of electricity and the patients come for many miles to attend the clinic and have their check-up. Clinic day is a real picnic for these patients—they meet their friends, visit in the vicinity and for the most part make the day an enjoyable one.

Apart from school and tuberculosis work, nursing care takes up the major portion of the nurse's time. She is on call at all times and is called out for anything from a toothache to a maternity case. The local midwife (practical nurse) attends most of the confinements, delivers the patient, does the house work and cares for the baby, all for a very small fee. However, as time passes and the public health nurse is being regarded without suspicion, the old midwife has fewer calls.

A special effort is made to teach the expectant mother to report her pregnancy early, so that she may be supervised, the doctor notified and all arrangements for delivery completed. The great tendency has been to call the nurse at the time of delivery when it is almost impossible to reach a doctor quickly. There is no hospital within ninety miles and the responsibility of transporting acute cases often rests entirely on the nurse.

The work is very interesting as there is such a variety of duties with never a dull moment. Let us spend one day with the nurse and follow her on her rounds. At six-thirty a.m. she is suddenly awakened by a banging noise which has by now become very familiar to her ears—the same as the "brrrr" of the telephone to the urban district nurse. It is no doubt—there is not much use hoping—a call. She hastily gets into slippers and dressing gown and steals quietly down so as not to awaken any other membebrs of the household.

There is Mr. M. looking very upset and worried—his wife is very sick, come quickly. The house is only five minutes walk away. Upstairs and into winter togs. What to take? Mrs. M. has had frequent prenatal visits but is not due for another month, as far as can be ascertained, so the maternity bag, always ready, is chosen. On arriving at the house—two rooms, a kitchen and a fairly large bedroom containing two beds, she beholds Mr. M. and his mother struggling with the patient who is in violent convulsions; she is rolling from side to side, tearing at whatever she may grab, her face flushed and eyes staring widely.

How many thoughts can go through one's mind at such a time—the doctor is thirty-six miles away and possibly out on a call, the telegraph office is not open until eight o'clock, how long would it take Dr. Y. to get here, it means a five hour drive by horse and sleigh. This is only a fraction of a minute's thought. She has a standing order for morphine to be given when necessary—she thinks this is surely a case of necessity. She remembers her training days—doctor's orders for convulsive patients were always not less than one-half grain, but should she give a half a grain— better not—try a quarter and see what happens. This turns out to be quite a task but finally the injection is given. Twenty minutes pass, no change, still the struggling continues—but there is no sign of labour pains, better try another quarter. After some time Mrs. M. quietens, relaxes and settles into a deep sleep.

With a sigh of relief the nurses looks ahead at the day which is now before her. Mrs. A. was confined three days ago and has developed a myositis. It will take two and a half hours to give her and the baby care. Mr. H.'s infected hand was improving with hot applications and prontylin but he is still a sick man. Maybe the icebreaker will come in today as two days have passed since

we wired for it. If, by any chance it should, Mrs. M. could also be removed to hospital. Oh well, better prepare Mrs. M.'s room for delivery—labour may start any time. She procures her basins from the maternity bag, forceps, cord tape, scissors, papers are found and the many other requirements for the confinement room. Mrs. M. is resting well, pulse is good. Instructions are left with the family and so home to breakfast.

By now it is well after eight o'clock. The nurse prepares for the usual rounds —out on foot. Mrs. M. is again visited; there is still little change, resting quietly. The telegraph office is on her way to Mrs. A.'s and so a report is sent on to Dr. Y. At Mrs. A.'s house things look much brighter; a comfortable home, cooperative family and Mr. A. with little to do, will stand in waiting for a return message from the doctor. She has finished the postpartum care of Mrs. A. and the baby is bathed and placed in her basket. Mr. A. brings back word that Dr. Y. is down at Meat Cove on a confinement case which means that there is no hope of even getting advice. There is no word from the M. family so the patient must be still quiet.

Up over the hill to the H. family and the infected hand. She looks out over the ice and to her great joy there is black smoke ascending—it must be the icebreaker. Her steps are hastened and yes, there is the family out in the yard with field glasses and it really is the icebreaker. There is great excitement getting the patient ready. His temperature is still high, his hand swollen and red, but soon he will have hospital care. Johnny rushes through the fields to borrow a horse and sleigh to transport his father to the boat. Arrangements completed here, she must go back to the M. family but there is quite a commotion at the back of the house. The icebreaker has failed to come within two miles off shore and is now turned and retracing its course. Such a disappointment! There is little to do but continue with what treatment can be given at home.

It is well on in the afternoon when she again enters the home of Mrs. M. who is now quite conscious and feeling well except for a few bruises. After a hasty lunch there are still several patients to be seen. There is the S. baby who is not retaining her feeding, old Mr. W. the chronic who watches at the window for her to come, and Sally convalescing from pneumonia.

By six p.m. she is home for the evening, she hopes. There is clerical work to be done though—the school reports from last week's inspection have not been completed. Outside it is snowing and the wind is howling, looks much like another storm, a typical night for a call. Only ten p.m. and there goes the knocking. It is none other than Mr. M., our visitor of the early morning, and this time his wife is in labour. Through the long hours of the night the nurse waits, with the awful dread that the patient may once more go into convulsions. But by four o'clock everything is over. A nice baby girl has arrived and strangely enough the mother looks bright and cheerful. Time now for a few hours sleep before starting another day.

Safety for the Worker

R. B. Morley

The Ontario Act dealing with Workmen's Compensation was the first in the Dominion of Canada and came into effect in 1915. It has been the model for other compensation acts in Canada, it has rid industry of litigation in dealing with injured employees and it has made for prompt and certain payment to those who were entitled to its benefits. In twenty-six years, the Workmen's Compensation Board has received reports on about 1,440,000 accidents and has awarded in benefits slightly over $140,000,000. which seems to put Workmen's Compensation into the category of big business.

Compensation is paid for accidents and for certain specified industrial diseases arising out of and in the course of employment, except where the disability lasts less than seven days or where the accident can be attributed solely to the serious and wilful misconduct of the worker although this factor is not considered when the accident results in death or serious disablement. In the case of fatalities, the widow, if any, receives a payment of $40. a month for life or until remarriage and, in the event of remarriage, she is entitled to a lump sum equivalent to pension payments for two years. There is an allowance of $10. a month for each child until the age of 16, but the total award paid to a widow and children does not exceed two-thirds of the average earnings of the worker. In other cases, the injured worker is entitled to two-thirds of his average earnings based on earnings up to $2,000 per annum. Where the injury is a permanent disability, compensation is paid in the form of a pension.

Under the Workmen's Compensation Act, medical aid and hospital services are now limited only by the needs of the case. In the early days of compensation in Ontario there was no allowance for medical aid and later an amendment allowed for medical aid up to 30 days. We had a case of a man, who was injured some years ago and was permanently totally disabled, and whose case was handled by the Workmen's Compensation Board on this unlimited basis. He had accommodation in the hospital, he had a doctor's care, he had a nurse in attendance. Such care is provided as a right under the Workmen's Compensation Act and not as charity. The regulations of the Board provide that employer and employee have an equal right in the selection of a doctor and in those few cases where these two cannot agree on a medical man, the Board will appoint one to look after the injury.

The prevention of accidents is sound, either from the economic or humanitarian point of view. When the Ontario Act was being drawn up, it was suggested that the industries be allowed to carry on some accident prevention work and the organization so set up be maintained out of the accident fund of the Workmen's Compensation Board. In Ontario, the industries in 21 of the 24 classes, have set up accident prevention organizations representing all or part of the Class. Of the 21 classes that have accident prevention associations, sixteen have federated for purposes of economy and better general direction of effort into the Industrial Accident Prevention Associations.

The work of the Industrial Accident Prevention Associations is divided

roughly into three headings: inspection in the individual plants; educational literature; and general service. We have inspectors whose duties take them into approximately 7,000 plants each year. Those men are trained for accident prevention purposes and do not go into an industry to enforce rules and regulations, although their work is based on the general rules and standards of the organization, which have been approved by the Workmen's Compensation Board and the Lieutenant-Governor-in-Council. These rules and standards are consequently law, but the inspector goes to a plant with a knowledge of industrial conditions, and of the specific situation in that plant and, after a talk with the plant manager, goes through the industry, noting conditions and subsequently makes any necessary recommendations for the correction of hazardous conditions. Our men also arrange plant meetings in which the accident situation is discussed either with all of the employees or with the foreman and other supervisors.

Our safety literature is, in effect, an advertising campaign carried on in the individual plants to persuade employees to assist in the control of accidents and the correction of hazards. Each month we put out the Memorandum for Industrial Executives, dealing with accident statistics, compensation costs and various phases of accident prevention. With that monthly letter, we issue at least four bulletins for shop posting so that a fresh one may be put up each week. There are also pamphlets addressed to foremen, to new men, and to truck drivers. There are pay envelope inserts, and once each year we issue the biggest piece of safety propaganda in Canada, the annual calendar.

We receive from the Workmen's Compensation Board a record of each accident involving a loss of seven days' time or more, and we call the attention of a plant executive to the necessity for control when his accident frequency reaches too high a point. The Workmen's Compensation Board also notifies us of all awards of $1,000. and over, and we receive a telephoned report of fatalities and certain other serious accidents, enabling us to get quickly to a plant where help may be needed.

Under a regulation issued by The Workmen's Compensation Board, there are certain specifications for the equipment for the first aid room and it is further required that this shall be in charge of "a clerk, workman, nurse or other person who has taken a recognized course of study in first aid to the injured." So that at last we have come down to the word "nurse" and the recognition of your profession.

In the last complete year for which figures are available, the Workmen's Compensation Board paid out money on 52,272 cases. Of these, 29,559 involved medical aid only. There was, presumably, a certain amount of lost time but the time lost was less than seven days in every one of these cases and, in consequence, only medical aid was allowed. This left a total of 22,713 cases, of which 21,501 involved temporary disability. That is to say, time was lost to the extent of seven days or more, and of these 21,501, there were 8,814 cases in which the disability terminated in one to two weeks after the accident. Others, however, ran almost a year and in 45 cases the disability was not terminated inside 52 weeks. Those 21,501 cases included bruises, contusions, abrasions, cuts, lacerations, punctures, fractures, crushes, sprains, scalds, eye injuries, dislocation and internal injuries. A doctor or a nurse in industry may therefore be called upon to handle numerous types of case. There were 41 cases of industrial diseases,

chiefly lead poisoning. The record shows a total of 7,362 persons who received compensation for falls alone, of which 3,720 were falls on the level. There were 936 permanent disabilities and 276 deaths and these involved about 60 per cent of the total cost.

Every one of the 52,272 cases mentioned involved possibilities of infection, as did the numerous cases that must have been dealt with in first aid rooms in literally thousands of plants. First aid and all that it implies is, therefore, important to both the industries and to the injured employees. In too many cases, the men seem to have taken the attitude that they were big, strong husky guys and that no germ had a chance in their systems. Consequently, the first opportunity that the first aid room has to deal with the problem is after infection has set in, making control doubly difficult. Efforts should be made to see that every break of the skin is treated in the first aid room, and that again is a point where your profession is interested.

Another important function that an industrial nurse can perform is that of the early recognition of diseases, whether those diseases are of the industrial type or not. A nurse who has reasonably close contact with the employees will soon learn to know whether individuals are up to par or not. A worker who is below par, and who forces himself beyond what is reasonable is rendering no immediate service to himself or to the employer. The control of industrial diseases and the control of infection is successful only when you reach the individual.

University of Toronto School of Nursing Refresher Courses

The School of Nursing of the University of Toronto announces a refresher course in Industrial Nursing for registered nurses interested in this subject, to be held from October 27 to November 1, inclusive. This course is given at the request of the Public Health Section of the Registered Nurses Association of Ontario, and with the co-operation of the Department of Health of Ontario and certain industries interested in health supervision.

The general content includes lectures on: Industrial Hygiene (a) general environment (b) personal health; Relationships within Industry from the point of view of (a) the Chief Executive (b) the Personnel Manager; Mental health problems in industry; First aid in industrial accidents; Public Health Nursing (a) general principles (b) industrial nursing: objectives, scope, and methods.

Round tables will be held dealing with community health service and the public health nurse; industrial nursing: opportunities, problems, and techniques. Observation visits will be arranged and a question box will be available.

All registered nurses interested in Industrial Nursing are eligible for enrolment. The registration fee for the course is $10.00.

The School of Nursing is also planning a refresher course for graduate nurses who are interested in the teaching of home nursing. This course will be given October 6, to 9, in the School of Nursing, University of Toronto, and will consist of lectures, demonstration lessons, and discussions. The fee will be $5.00. The proposed content is as follows: Lectures on the psychology of learning; the principles of teaching; emergency nursing with special reference to war time work; recent developments in medical research. A series of demonstration classes will be taught, the topics for these being selected from the Red Cross Manual and the supplement entitled Emergencies in War. These demonstrations will be followed by discussion classes.

Rural Canadian Medicine

When Mr. George Hoadley, former minister of agriculture and health in Alberta, recently addressed the convention of the United Farmers of Ontario he had some things to tell them of medical care, or the lack of it, in rural Canada which do not make pleasant reading. Especially disturbing were his figures of ten thousand babies lost each year before they reach their first birthday, with the added statistic that Canada's rate in this class was 76 per thousand, against New Zealand's 30 per thousand. "Our wastage of mother and child life is national suicide," concluded Mr. Hoadley. Mr. Hoadley mentioned the record of districts which have appointed municipal doctors, and his optimism is borne out by figures in this province. Dr. F. W. Jackson, deputy Minister of Health, in a report on Manitoba's twelve municipal doctor districts, stated :

From the standpoint of public health, the establishment of municipal doctors would seem to be an excellent way of bringing to our rural districts all those methods that are now available for the prevention of disease and the preservation of health. We find that the doctor soon begins to think and work towards prevention and he finds that this is bound to react to his benefit in lessening calls for actual illness and emergency. Vaccination and diphtheria toxoid administration is practically complete in the municipal doctor areas and is carried on as routine year by year. Pre-natal care is far more adequate in these districts than that generally found in rural areas, and possibly can account for the fact that the maternal mortality rate in these areas is less than the general rate in the province.

The cost, by the way, in Manitoba works out to approximately $2.00 per head of population of the area, or from $4.50 to $5.00 per quarter section.

Manitoba has another figure to bring forward in this discussion and it is that discovered in the survey which has gone on over this province in regard to the maternal mortality rate. Doctors were asked to make a report on maternal deaths in their practice—and almost at once this rate began to go down. There is only one conclusion which can be drawn from this circumstance, and it is that the survey has jacked up the medical profession itself. There is a suggestion here for the profession not only in this province but throughout Canada. There is still much work to be done on the Manitoba survey. When it is completed its findings will be of outstanding value to doctors and it is to be hoped that it will be studied by them, and made available to medical colleges.

In the session of the Federal House before the outbreak of war, there was a long debate on a proposal to provide health examinations and treatments for disease. Some figures emerged which are of general interest. One of these is that three to four per cent of the population of Canada are constantly sick and under medical care. Approximately $300,000,000 is spent annually for medical treatment in the Dominion. Only $6,000,000 is spent in preventive medicine.

Beyond a doubt there are arguments against state medicine. Beyond a doubt there are arguments for it, and not the least strong of these is the record now established by municipal doctors in these three western provinces. Some of this record is the emphasis upon prevention, a factor of significance in the gradual evolution of medical practice which is going on under our very eyes.

—From *The Winnipeg Free Press*

STUDENT NURSES PAGE

Nursing Care of Secondary Syphilis

ELIZABETH E. GOODWIN

Student Nurse

The Montreal General Hospital School for Nurses

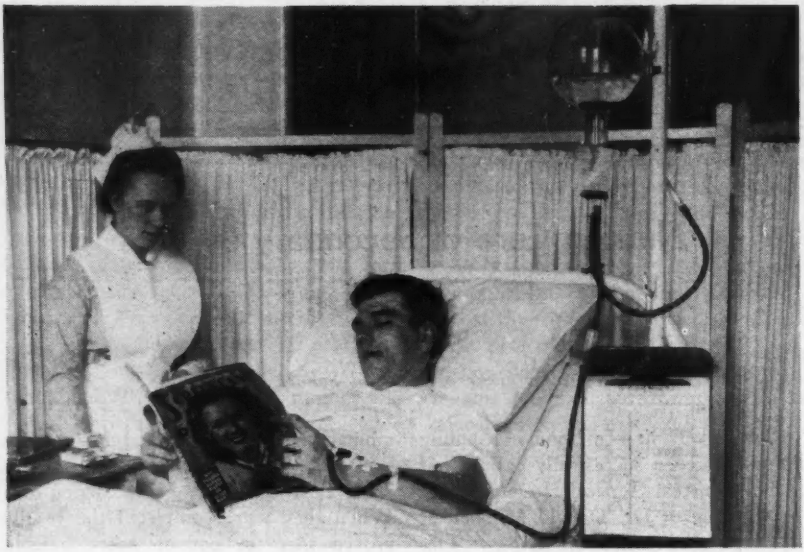
A relatively new method of treating syphilis has been successfully carried out in the Montreal General Hospital under the direction of Dr. Donald Mitchell of the department of dermatology. This treatment calls for intensive nursing care, careful observation and relatively complicated techniques and an account of it may prove helpful to other nurses.

The treatment was used for three male patients whose respective ages were eighteen, twenty-three, and fifty-three. Two were unmarried, the third was married but had no family. These men were admitted during the second stage of the disease and before the end of the eighth week following infection. There were ulcerative chancres on the genitalia. A reddish-brown macular rash was present over the entire body and extremities in two instances while, in the third, the patient was covered with numerous pustules of different sizes, some being as large as a ten-cent piece.

Before treatment could be carried on, several tests were necessary and accordingly the following tests were done: blood Wassermann; Laughlen tests; blood chemistry; cultures were taken from discharging chancres; urinalysis; urobilinogen; urea concentration factor; galactose tolerance tests; ophthalmic examinations; visual fields; chests were x-rayed. The men were allowed up while their tests were being carried out. When they were completed the results proved that the patients were suitable cases for therapy, that is that their physical condition was such that no undue risk would be involved by intensive treatment. Chemotherapy by the drip method was then started.

Massive dose chemotherapy has several advantages over the previous method of treating the disease. The period of treatment is shorter and therefore there is less possibility of treatment being abandoned before it is effective as so often happens when it is given over a period of years. Because less time away from work is required, it seems simpler to the patient and he is more willing to accept it. The danger of spreading infection is lessened because the patient is hospitalized and cured while otherwise, he is free and, for a time, infectious. No stigma is attached to hospitalization as there may be when the patient must attend a public clinic.

Every morning at 8 a.m., after the patients had taken a tub-bath and had had their breakfast, they returned to bed. The needles were inserted into the vein and held firmly in place by several



narrow strips of adhesive. The veins on the outer and inner aspects of the forearm were chosen, at some distance from a joint. Short needles and short glass adapters were used to provide more freedom. The patients were allowed carefully limited movement of the arm. Mapharsen, 120 mgms., was added to each 1200 cc. of 5% dextrose in distilled water. A total dosage of Mapharsen 1200 mgms. in 12,000 cc. of solution were used over the five-day period. We used the inverted type of flask and filter with detoxicated connecting tubing and a Murphy drip. The solution ran into the vein at the rate of 64 to 68 drops per minute or approximately 10 cc. in three minutes, and at room temperature. We at first thought it advisable to warm the solution by means of hot water bottles placed against the tubing. However, when it was discovered that solution heated in this way was only two degrees higher in temperature than that in the tubing warmed only by the patient's arm, this technique was abandoned.

This continuous intravenous drip method of injecting the drug did not interfere with the routine nursing care or limit the men's activities while lying in bed. They ate their meals, washed their faces and hands, had their backs rubbed, smoked when they wanted to, read magazines, and played games. The addition of a radio to their room improved the environment and freed their minds from their treatment and from themselves. Temperatures, pulses and respirations were taken every two hours and often checked more frequently. Their diet was as desired. Intake and output were measured and sedatives were not necessary.

Half an hour before the needle was to be withdrawn on the fifth day, the youngest patient had a chill. The intravenous was not terminated until all the solution had been injected and his temperature rose to 102 degrees. The fol-

lowing morning his temperature was 103 degrees and a generalized macular rash reappeared over his body and extremities. Spongings were given every four hours and the patient reacted very well. The rash began to fade on the third day and the temperature fell to normal but again rose and persisted for two days.

On completion of the injection, all tests which had been done previously were re-checked. The only change noted was a slight increase in blood urea. Dark field examinations proved negative at the end of forty-eight hours, and the Wassermann tests were still negative on completion of treatment. However, patients do not become immune and may become re-infected.

Reactions which were to be looked for were: primary or secondary fever; toxicoderma; exfoliative dermatitis; blood discrasia; renal damage; jaundice; peripheral neuritis; cerebral complications such as hemorrhagic encephalitis. On discharge from the hospital, the social service department followed up the three patients to insure their weekly return to the clinic for repeated blood Wassermann and general check-up.

Book Reviews

Essentials of Pharmacology and Materia Medica for Nurses, by Albert J. Gilbert, M.D., Instructor of Pharmacology, Aultman School of Nursing, Canton, Ohio; and Selma Moody, R. N., Instructor in Nursing Arts, the Presbyterian Hospital, Chicago. 251 pages. Illustrated. Published by the C. V. Mosby Company; Canadian agents: McAinsh & Co. Ltd., Toronto. Price, $2.75

The busy instructor who is looking for assistance in determining the essentials in a course in materia medica and pharmacology for nurses will find this book helpful. While it is less comprehensive than many text-books on the subject, adequate reference reading is included. Each important drug is discussed as to preparation, dosage, mode of administration, action and uses, and untoward effects . The chapters on drugs and solutions, and posology, give especially clear and concise information for the junior nurse. In introducing discussion on the factors which enter into the determination of doses the writer says: "Although the nurse will not have to determine the amount of drug Mr. Brown should have, she will give him the prescribed drug and will report to the physician just what results are being obtained through its administration. The nurse, then, who represents the best in her chosen profession is going to be keenly interested in the factors which have influenced the physician's decision regarding Mr. Brown's dose." In an appendix the official doses of important drugs are listed in both metric and apothecary systems, and suggested questions for study are included. The general arrangement, type-forms and illustrations all contribute to an increased interest in the subject matter.

Principles of Microbiology, by Francis E. Colien, B.S., M.S., Ph.D., R.A.P.H.A., Assoc. Professor of Bacteriology and Preventive Medicine, Creighton University School of Medicine; and Ethel J. Odegard, R.N., M.A., Instructor in sciences applied to nursing, College of Saint Teresa, Winona, Minn. 444 pages. Illustrated. Published by the C. V. Mosby Company; Canadian agents: McAinsh & Co. Ltd., Toronto. Price $3.50

The material for this book has been developed from the author's experience in teaching the subject to student and graduate nurses during the past fourteen years. The principal divisions are: introduction to the study of microorganisms; destruction of

microorganisms; classification and related subjects, microbiology and nursing; infection and immunity; pathogenic microorganisms; microbiology in relation to water and milk. The emphasis is on the application of microbiology to nursing and disease prevention. In a chapter entitled microbiology and nursing, some main points considered are the promotion of medical asepsis, responsibilities of the nurse administrator and of the bedside nurse, and the nurse as a health teacher. The use of diagrammatic presentation, as in the discussion on immunity, is helpful to the student. The appendix includes preparation of culture media, a suggested laboratory program, and a good glossary. The exercises and demonstrations in the laboratory program provide worthwhile suggestions for the instructor in this subject. The many illustrations and numerous colour plates add considerably to the value of this well-prepared book.

Learning How to be Blind

Some of the civilians who have lost their sight in air raids are to pass the early days of their blindness at Long Meadow, Goring-on-Thames, where experts of the National Institute for the Blind will teach them how to lessen the harshness of their disability. As friend and adviser, these people will have with them Sir Beachcroft Towse, V. C., the blind owner of Long Meadow, who has put his lovely home at the disposal of the National Institute for training the newly blind. The presence of Sir Beachcroft at Long Meadow is regarded as an invaluable asset. His brave confidence and bearing should be an inspiration to his guests at the beginning of their own dark journey.

Experience gained at Long Meadow will be useful to the Institute at any further centres that may be required, but the staff of each will comprise specially trained blind men and women. These "homes of recovery" are intended for adults. Little children will be trained at the Institute's Sunshine Homes for Blind Babies, and boys and girls of school age at existing schools.

Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

Miss Frances Scoville, a graduate of the Winnipeg General Hospital, and of the public health nursing course at the University of Toronto, has been appointed to the staff of the Ottawa Branch.

Miss Caroline Flynn, a graduate of the Children's Hospital, Halifax, and of the public health nursing course at the School for Graduate Nurses, McGill University, has been appointed to the staff of the Halifax Branch.

Miss Margaret Graham, a graduate of the University of Alberta Hospital Bachelor of Science in Nursing, has been appointed to the Edmonton staff.

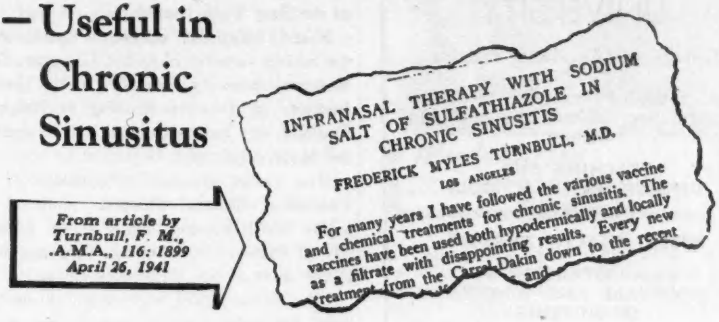
Miss Lena Riddell, a graduate of the Montreal General Hospital, has completed the public health nursing course at the Institute of Public Health, University of Western Ontario, and has been appointed nurse-in-charge of the York Branch, replacing *Miss Louise Curtis* who is taking a year's leave of absence.

Miss Mary Plishka, a graduate of the University of Alberta Hospital, and of the public health nursing course at the University of Toronto, has been appointed to the staff of the Oshawa Branch.

Miss Françoise Latour, a graduate of the Hotel-Dieu Hospital, Montreal, and of the public health nursing course at the University of Montreal, has been appointed temporarily to the staff of the Ottawa Branch.

SULFATHIAZOLE SODIUM SESQUIHYDRATE

—Useful in Chronic Sinusitus



A new therapy for chronic sinusitis has been reported by Dr F M. Turnbull. Patients were instructed to spray the nasal passages twice daily with a 5% solution of Sodium Sulfathiazole Sesquihydrate. O the 47 patients so treated 40 reported definite symptomatic relief. Nasal passages were opened drainage promoted and congestion and pressure headaches relieved

The 5% solution of Sulfathia zole Sodium Sesquihydrate recommended by Dr. Turnbull is isotonic An all glass atomizer shou.d be used to prevent undue discoloration and only enough solution should be prescribed for about a week's medication. Slight discoloration has no significant effect on potency The solution (or the dry powder) should never be placed in closed cavities or used for irrigation where it may remain in contact with the tissue for a considerable period of time

Sulfathiazole Sodium Sesqui hydrate Squibb is supplied n staple powder form n 5 gram and 50 gram bottles

For literature address E. R. Squibb & Sons of Canada, Ltd.
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E·R·SQUIBB & SONS OF CANADA, Ltd.
MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

Miss Evelyn Oldershaw, a graduate of the Brantford General Hospital, and of the public health nursing course at the University of Toronto, has been appointed to the staff of the East York Branch.

Miss Gladys McLachlan, a graduate of the Stobill General Hospital, Glasgow, Scotland, and formerly a member of the Queen's Institute of District Nursing at Brighton, England, has been appointed to the staff of the Montreal Branch.

Miss Isabel Mungen, a graduate of the Vancouver General Hospital, and of the public health nursing course at the University of British Columbia, has been appointed to the staff of the Vancouver Branch.

Miss Bessie Julien, a graduate of the Victoria Hospital, London, and of the public health nursing course at the Institute of Public Health, University of Western Ontario, has been appointed temporarily to the staff of the York Township Branch.

Miss Eleanor Fothergill and *Miss Lois Croft,* graduates of the Victoria Hospital, London, and of the public health nursing course at the Institute of Public Health, University of Western Ontario, have been appointed to the staff of the Kitchener Branch.

Miss Laura Wall has been transferred from the staff of the Winnipeg Branch to take charge of the branch in New Liskeard, Ontario, replacing *Miss Bessie Skinner,* who has been transferred to the York Township staff.

Miss Marguerite Tanguay has been transferred from the Halifax Branch to the Kirkland Lake staff, replacing *Miss Elsie Carter* who has been appointed nurse-in-charge of the new branch in Windsor, Nova Scotia, which was opened on the first of August.

Miss Jean Hamilton, Miss Edythe Cole, and *Miss Roberta Heatlie* have resigned from the Montreal staff to be married.

Miss Grace Ewing has resigned from the East York staff to join the R.C.A.M.C. Nursing Service.

Miss Lois Black has resigned from the staff of the York Township Branch to take a position in industrial nursing.

Miss Ruby McCallum has resigned from the staff of the Truro Branch.

Ontario Public Health Service

Miss Oleavia Chant (Buffalo City Hospital and University of Toronto public health nursing course) who has been in Haileybury, has resigned to accept a position as public health nurse in Kenora. This is a new service.

Miss E. C. McLeod (Toronto General Hospital and public health nursing, Teachers College, Columbia University) has accepted a position as industrial nurse with the Atlas Steel Company, Welland.

Miss Betty Robinson (Oshawa General Hospital and University of Toronto public health nursing course) has resigned her position as public health nurse in Dryden. She has been succeeded by *Miss Ruth Macdonald,* a graduate of the Ottawa Civic Hospital and University of Toronto public health nursing course.

Miss Edna Bell (Hamilton General Hospital and University of Toronto public health nursing course) has resigned her position on the staff of the Hamilton Department of Health to accept the post of public health nurse in Swansea. She succeeds *Miss Helen Watson* who is leaving to be married.

Miss Margaret Smith (Victoria Hospital, London, and University of Western Ontario public health nursing course) has accepted a position with the United Counties Health Unit. Miss Smith succeeds *Miss Marjorie Rutherford* who has been granted leave of absence to serve as Nursing Sister with the R.C.A.M.C.

Miss Evelyn Newson (Toronto Western Hospital and University of Toronto public health nursing course) has resigned her position at Hydro to go to the Fort William Sanatorium as public health nurse. Her district includes the cities of Fort William and Port Arthur and surrounding area.

Miss Lois Black (Guelph General Hospital and University of Western Ontario public health nursing course) has received the appointment of industrial nurse with the munitions plant at Pickering. Miss Black has been with the Victorian Order of Nurses in York Township.

Miss Mildred Wilkins (Wellesley Hospital, Toronto, and University of Toronto

public health nursing course) has been appointed industrial nurse with the Spruce Falls Power and Paper Company at Kapuskasing. Miss Wilkins recently resigned from the Division of Nursing, Toronto Department of Health.

Miss Aubra Cleaver (Toronto General Hospital and University of Toronto public health nursing course) has succeeded Miss Chant in Haileybury.

Miss Elizabeth Carter (University of Alberta Hospital and University of Toronto public health nursing course) is relieving on the staff of the Board of Education, Owen Sound.

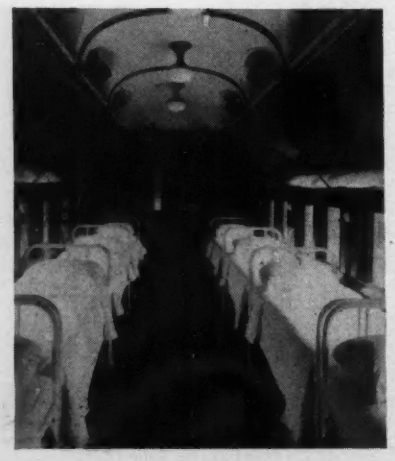
Mrs. Archange Liles (Ottawa General Hospital and University of Montreal public health nursing course), and *Miss Presentine Perrin* (St. Joseph's Hospital, Lachine, Quebec, and University of Montreal public health nursing course) have joined the nursing staff of the Ottawa Board of Health.

Miss Annie Boyd, of the Nursing Supervisory staff, Hamilton Department of Health, has been granted leave of absence for the duration of the war. She has received the appointment of Matron at the Military Hospital, Hamilton. *Miss Irene Mayall* of the nursing staff has also been granted leave of absence for the duration of the war.

Miss Hattie Sabine recently resigned from the staff of the Hamilton Department of Health after twenty years of service.

The following appointments have been made recently to the Hamilton Department of Health, Division of Nursing: *Miss Margaret Anderson,* B.Sc.N., University of Western Ontario; *Miss Grace Smith,* Hamilton General Hospital and University of Western Ontario public health nursing course; *Miss Margaret Goodes,* Hamilton General Hospital and University of Toronto public health nursing course; *Miss Elma Ward,* B.Sc.N., University of Western Ontario; *Miss Evelyn Watts,* Hamilton General Hospital and University of Toronto public health nursing course; *Miss Isobel Deeth,* Hamilton General Hospital and University of Toronto public health nursing course; *Miss Barbara Leeper,* Oshawa General Hospital and University of Toronto public health nursing course.

Hospital Car for Canadian Casualties



The first unit prepared at the Montreal shops of the Canadian National Railways for the Royal Canadian Army Medical Corps was obtained by converting a sleeping car. For convenience in placing stretcher cases on board, extra wide doors were provided at each side allowing ample room on entering and leaving the hospital unit. Cots replace lower berths, allowing greater convenience in assisting serious surgical cases being conveyed from the seaboard to hospitals in the interior of the Dominion. The upper berths remain, and may be used by casualties of less serious order. The car contains a dispensary, kitchenette, a room for surgical dressings, a room for the doctor in charge, the usual drawing-room having been left for the accommodation of three nurses.

NEWS NOTES

ALBERTA

EDMONTON:

Royal Alexandra Hospital:

Honouring Miss F. Martyn of Hartford, Conn., the Royal Alexandra Hospital Alumnae Association recently held a reception in the nurses home. Miss Martyn, who is one of the early graduates of the R. A.H., recounted many of her interesting experiences as a student, and later as a graduate nurse in various parts of the world. During the evening, Miss Martyn presented to the Alumnae Association a miniature of Queen Alexandra for whom the Hospital is named. The painting was done on ivory by an English artist, Mrs. McManus, in the latter part of the nineteenth century.

Miss Anne Jarvie, who was granted the Alumnae Scholarship award, is now at the Royal Victoria Hospital, Montreal, where she is taking a post-graduate course in surgery. Miss Constance Clemens is leaving to take over duties as instructor of procedures at the Moose Jaw General Hospital. Miss Irene Toby, B.A., who spent last year doing post-graduate work at the School for Graduate Nurses, McGill University, has returned to the R.A.H. Training School staff.

LETHBRIDGE:

Perfect weather and an ideal setting provided a lovely background for a garden party at Galt Hospital grounds at which approximately ninety dollars was taken in aid of the British Nurses Relief Fund. The event was sponsored by Lethbridge District 8 of the A.A.R.N., and student nurses of Galt Hospital. Miss Frances Harvey, superintendent of nurses, received while Mrs. Ernest Flinn, née Alice Dacre; Mrs. K. I. Murray, Mrs. Mae, and Mrs. Kipp presided at the tea table.

Miss Christine McLennan has accepted a position in Fort William and Mrs. C. Gregory is now in a hospital in Bellvue, Alberta.

NOVA SCOTIA

HALIFAX:

A special meeting of the Halifax Branch, R.N.A.N.S., was recently held for the purpose of hearing Miss M. E. Tennant, advisor in nursing, Rockefeller Foundation. Miss Tennant spent two weeks in Nova Scotia visiting the various training schools of the Province. The meeting was interesting and well attended. Miss Tennant spoke of her work in the various countries of Europe, in China, and Japan, and in several of the South Pacific Islands. The loyalty and devotion of the Polish nurses was emphasized, which made us realize that our difficulties are very trivial in comparison.

Victoria General Hospital:

The Victoria General Hospital recently held the graduating exercises of the School of Nursing, when 22 nurses received their diplomas. C. J. Burchell, K.C., newly- appointed Canadian High Commissioner to Newfoundland, and former High Commissioner to Australia, was chairman. Mr. C. B. Smith, K.C., delivered the address to the graduates. He stressed the need of courage and self-sacrifice and told them they were going out on their profession of mercy at a time when the world had greater need of them than ever before. The prize winners were Miss Barbara Scott Nelson, Miss Marion Swansburg, and Miss Marie Mallett. Four student nurses entertained the audience with two vocal selections.

Miss Adelaide Munro (Winnipeg General Hospital and McGill School for Graduate Nurses) has been appointed superintendent of nurses at the V.G.H. Miss Ada Stanley (Brandon General Hospital) has been appointed assistant superintendent of nurses at the V.G.H. Miss Ellen T. Hugill, B.Sc. (University of Alberta Hospital) has been appointed to the staff of the Dalhousie Public Health Clinic. Miss Jean Church, B.Sc. (Royal Victoria Hospital) has been appointed to the staff of the Children's Hospital.

NEW GLASGOW:

Aberdeen Hospital:

The Alumnae Association of the Aberdeen Hospital recently held their annual picnic at the summer home of Mrs. J. T. Cumming, the vice-president, at Melmerby Beach. There were 20 members present.

ONTARIO

DISTRICT 1

SARNIA:

Sarnia General Hospital:

The Alumnae Association of the Sarnia General Hospital entertained the graduating class at dinner recently. Miss Myrtle Thompson was mistress of ceremonies and Miss Frances Harris, president of the Alumnae Association, received with her. Miss J. Revington proposed the toast to the king. The toast to His Majesty's forces on land sea and air, was proposed by Mrs. Elrick. Miss Dodge replied to the toast to the alma mater proposed by Mrs. Kennedy. The toast to the Alumnae was given by Miss M. McPhedran and Mrs. Luckhurst responded. Miss Shaw gave the address and toast to the graduating class and Miss Acton, senior of the class, replied. Following the dinner the student nurses entertained the graduating nurses at a dance, when the guests were received by Dr. and Mrs. Rutherford, Dr. and Mrs. W. G. Gray, and Miss Shaw. The members of the grad-

uating class were presented with thermometers, gifts of the student nurses. The graduate staff also entertained for the graduating class and their friends. This took the form of a garden party at which Miss Shaw and Miss MacFarlane received the guests. The graduating exercises for the twenty-four graduating nurses were held in the Sarnia collegiate. Miss Mabel Hoy of Windsor gave the address. Mrs. W. J. Hanna presented the diplomas and Mrs. Brown presented the pins. Following the exercises the invited guests were entertained at a dance.

Married: Recently, Miss Abigal Parker (S.G.H., 1931) to Mr. Ken. McIntyre.

District 4

ST. CATHARINES:

The summer meeting of District 4, R.N.A. O., was held recently at the Leonard Nurses Home, St. Catharines. Dr. Binns, of Welland, gave an interesting lecture on some aspects of the war as it affects the medical and nursing professions. A social hour followed, with Miss Anne Wright, superintendent of the Hospital, as hostess. The fall meeting will be held in October at St. Joseph's Hospital.

The following members of District 4 have joined the new Hamilton Military Hospital: Miss Florence Thompson, Niagara Falls General Hospital; Miss Agnes Stewart, Hamilton General Hospital; Miss Irene Mayall, Hamilton General Hospital; Miss Mary Trenaman, Hamilton General Hospital; Miss Maye Morrow, Hamilton General Hospital; Miss Annie B. Boyd, Hamilton General Hospital; Miss Ivy Hart, St. Joseph's Hospital; Miss Elizabeth Cocker, St. Joseph's Hospital; Miss Jessie MacNaughton, St. Joseph's Hospital.

District 9

GRAVENHURST:

The nurses of Muskoka Hospital recently held a garden party in aid of the British Nurses Relief Fund, when $135. was realized.

QUEBEC

MONTREAL:

Montreal General Hospital:

Miss Holt and staff entertained at tea recently in honour of three members of the nursing staff, Miss M. Baxter, Miss H. Legere, and Miss M. K. McLeod who have resigned to be married. Suitable gifts were presented to the brides elect.

Recent appointments: Miss M. M. McDonald (1939) replaces Miss Baxter in ward A; Miss Ellen Reid (1930) replaces Miss Grindley, who has resigned as director of health service; Miss Mary Abbott (1941) has joined the nursing staff. Miss Esme Labréque (1940), nursing sister with the R. C.A.F., has been transferred from St. Thomas, Ont., to No. 1 Wireless School,

Montreal. Miss Edythe Ward (1923), Miss Isabel Lamplough (1929), and Miss Julia Andrews (1941) have been chosen to serve as nursing sisters with the South African military hospitals.

Married: Recently, Miss D. Helena Legere (M.G.H., 1934) to Captain Joseph B. McDonald, R.C.A.M.C.

Married: Recently, Miss Miriam Shaw (M.G.H., 1934) to Lieut. Marschall E. Nash, R.C.O.C., A.C. United States.

Married: Recently, Miss Marion A. Baxter (M.G.H., 1932) to Captain Fergus D. Johnston, R.C.A.M.C.

Married: Recently, Miss Gertrude Arnoldi (M.G.H., 1912) to Dr. Edmund M. Eberts.

Married: Recently, Miss Helen Duchek (M.G.H., 1936) to Mr. Henry Wise.

Royal Victoria Hospital:

Among those present at a reception arranged for members of the nursing profession from overseas on war service by the Association of Hospital Matrons in Cowdray Hall, Royal College of Nursing, were Nursing Sisters Janet MacKay and Helen Kendall, from No. 1 Neurological Hospital; Sister Margaret Desborough, from No. 14 Canadian General; and Sister Mary Maguire from No. 1 Canadian General Hospital. The significance of the occasion was heightened by the presence of Her Majesty Queen Elizabeth who chatted with the guests after tea.

The following graduates are attending the School for Graduate Nurses, McGill University: Miss Margaret Street, Miss Dorothy Dick, Miss Muriel MacKenzie, Miss Elizabeth Lyster, Miss Bertha Reid, and Miss Eleanor Fraser.

Miss Winnifred MacLeod, who has been in charge of the nose and throat ward, has been appointed night supervisor at the Alexandra Hospital.

Mrs. Robert Carpenter (Jessie Cruise, Class of 1920) and her two sons were visitors from Buffalo, N.Y.

Married: Recently, Miss Mildred Chambers (R.V.H., 1925) to Mr. Reginald Harcourt Little.

Married: Recently, Miss Muriel Peake (R.V.H., 1940) to Aircraftman Elden Edmund Spencer, R.C.A.F.

School for Graduate Nurses, McGill University:

Miss May Reid (T. & S., 1939) has transferred from the Grey Nuns Hospital, Saskatoon, to the Vancouver General Hospital. Miss Helen MacKay (T. & S., 1939) has transferred from the Woman's General Hospital, Montreal, to the Royal Inland Hospital, Kamloops, B. C. Miss Ellen T. Hugill (T. & S., 1939) has transferred from the Children's Hospital, Halifax, to Dalhousie Public Health Clinic. Miss Helen Wilson (T. & S., 1940) has transferred from the Winnipeg General Hospital to Aberdeen Hospital, New Glasgow, N. S., as superintendent of nurses.

Miss Lucille McAlister (P.H.N., 1939) has accepted a position at Westbank, B. C. Miss Jean Church has been appointed to the staff of the Children's Hospital, Halifax. Miss Kathleen Durrell, Miss Katherine MacLean, and Miss Margaret Tedford have been appointed to the staff of the Saskatoon City Hospital. Miss Victoria Antonini has been appointed to the staff of the Regina General Hospital. Miss Jessie Cook has been appointed to the Woman's General Hospital, Montreal. Miss Alice Gage and Miss Lillian Athelstan have returned to the Homoeopathic Hospital, Montreal. Miss Hilda Bartsch has been appointed to the staff of the Alexandra Hospital, Montreal. Miss Gladys McDonald has been appointed to the Health Department, Regina, Sask. Miss Eleanor Martin has been appointed to the Teaching Department of the Royal Victoria Hospital, Montreal. Miss Mary Morrison has been ap-

pointed to the staff of the General Hospital, Cornwall, Ont.

Miss Ethel Richardson has returned to the Children's Memorial Hospital, Montreal. Miss Margaret Scarrett has returned to the Toronto General Hospital. Miss Gwen Thomas has returned to the Vancouver General Hospital. Miss Frances Toby has returned to the Royal Alexandra Hospital, Edmonton. Miss Martha Watt has returned to the Hamilton General Hospital. Miss Edna Trerice has returned to the Health Department, Nova Scotia. Miss Elizabeth Whiston, having completed a post-graduate course at the Alexandra Hospital, Montreal, has been appointed to the staff of the Victorian Order of Nurses, Halifax.

The following have joined the staff of the Victorian Order of Nurses: Miss Eileen Brelgtaff, Miss Dorothy Campbell, Miss Jill Flynn, Miss Rita Michaud, Miss Jessie Morris, Miss Margaret Mullin, Miss Therese Terrien, and Miss Jessie Jackson. Miss Peggy Dakin and Miss Doris Wilson are with No. 14 General Hospital.

Recent visitors at the school for Graduate Nurses were: Miss Marjorie Cowan (P. H.N., 1940) Regina, Sask.; Miss Rita Myers (P.H.N., 1939) Darmouth, N. S.; Miss Lillian Pettigrew (P.H.N., 1939) Toronto; and Miss Martha Earle (P.H.N., 1940) Newcastle, N. B.

Married: Recently, Miss Eva B. Hamilton (T. & S., 1939) to Mr. E. A. Moore.

Married: Recently, Miss Roberta Heatlie (P.H.N., 1938) to Mr. Gerald Phelps.

Married: Recently, Miss Edith Cole (P. H.N., 1940) to Mr. John Dundass.

Married: Recently, Miss Anna B. M. Simpson to Mr. Roland Labonté.

NEWFOUNDLAND

ST. JOHN'S:

Grace Hospital:

The graduation exercises of Grace Hospital Training School were held recently in Pitts Memorial Hall. The graduating class marched past a guard of honour formed by the student nurses of the hospital and took their places on the beautifully decorated stage. Commissioner Orames of Toronto was the chairman for the evening. The diplomas and pins were presented by Mrs. J. B. O'Reilly, and the scholarships and prizes by Dr. W. Roberts. Miss Margaret Parsons delivered the valedictory on behalf of the graduating class.

An important event in Grace Hospital activities for the month of June was the publication of the second edition of the students' magazine, "The Bib and Apron". This magazine entails a lot of work, organization and time, and much credit is due to Miss Robbins and her committee for such a fine edition.

. . . OFF . . . DUTY . . .

For some obscure reason that we are unable to fathom . . . there are certain groups of people to whom it seems easy to turn for help when one is in trouble . . . Among them are those whose task it is to transport the public hither and yon in ships, trains and buses . . . We shall always remember with gratitude a certain stewardess on a Channel steamer who on more than one occasion restored our morale and straightened our hat after a rough crossing had reduced us to a dismal pulp . . . Although we had no such intimate contact with the high command . . . we cherish a boundless admiration for sea captains in the merchant service who can christen, marry or bury you, according to your social need . . . We feel the same way about conductors, engineers and trainmen . . . especially Pullman porters . . . No vagary of human nature ever seems to surprise them and the emergencies of travel are an old story with which they deal firmly and kindly, whenever and wherever they arise . . . These men seem to know that the changes and chances of travel by sea or land partake of the uncertain quality of life itself, and that every journey is an excursion into the unknown . . . Unfortunately this calm philosophy is not shared by those who work on trams and underground railways . . . too many sudden stops and starts . . . too many tired and irritable passengers . . . no time to get to know one another . . . In town, buses are like that too . . . but once they get away from the crowded streets and the traffic lights they are less ferocious . . . We are personally acquainted with a bus that picks us up in the morning . . . and carries us into the heart of the Laurentian autumn woods . . . At dusk it brings us back again and drops us at the corner of our own street . . . The other day we went to the terminal ready for an early start . . . and noticed a small boy who was evidently in trouble . . . but unwilling to tell us what was wrong . . . Presently our bus driver came along . . . took him on one side and spoke to him as man to man . . . He had come to visit an uncle . . . but the house was locked up . . . and there was no money for the return home . . . We offered a small donation . . . but it was quietly waved aside . . . The driver gravely let the lad sign a promise to pay and sent him to buy a ticket . . . "The family are poor", he said, "but they would not like him to take money from strangers" . . . After awhile we were out in the country, on the road which winds along beside the river . . . The boy got off at a little farm . . . but when we came back in the afternoon there he was . . . waiting for the bus to stop . . . Proudly he redeemed his promissory note . . . and took off his cap to us politely . . . "A man would rather pay his own way", said the driver meditatively, "you must not take away self-respect" . . . "No", we said, "you mustn't" . . . and pulled the cord for our corner.

—E. J.

Official Directory

International Council of Nurses

Acting Executive Secretary, Miss Calista F. Banwarth, 310 Cedar Street, New Haven, Connecticut, U. S. A.

THE CANADIAN NURSES ASSOCIATION

President..... **Miss Grace M. Fairley, Vancouver General Hospital, Vancouver, B.C.**
Past President Miss Ruby M. Simpson, Department of Health, Parliament Buildings, Regina, Sask.
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Ontario: (1) Miss Jean L. Church, 120 Strathcona Ave., Ottawa; (2) Miss L. D. Acton, General Hospital, Kingston; (3) Miss G. Ross, 15 Queen's Park Crescent, Toronto; (4) Miss D. Ogilvie, 34 Gilchrist Ave., Ottawa.

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Saskatchewan: (1) Miss Matilda Diederichs, Regina Grey Nuns Hospital; (2) Miss A. F. Lawrie, Regina General Hospital; (3) Miss Gladys McDonald, 6 Mayfair Apts., Regina; (4) Miss R. Wozny, 2216 Smith St., Regina.

Chairmen, National Sections: Hospital and School of Nursing: Miss B. Anderson, Ottawa Civic Hospital. Public Health: Miss M. Kerr, Eburne, B.C. General Nursing: Miss M. Baker, 249 Victoria St., London. Convener, Committee on Nursing Education: Miss M. Lindeburgh, School for Graduate Nurses, McGill University, Montreal.

Executive Secretary: Miss Jean S. Wilson, National Office, 1411 Crescent St., Montreal, P.Q.

OFFICERS OF SECTIONS OF CANADIAN NURSES ASSOCIATION

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Chairman: Miss Blanche Anderson, Ottawa Civic Hospital. First Vice-Chairman: Miss E. G. McNally, General Hospital, Brandon. Second Vice-Chairman: Miss M. Batson, Montreal General Hospital. Secretary-Treasurer: Miss W. Cooke, Ottawa Civic Hospital.

Councillors: Alberta: Miss H. S. Peters, University Hospital, Edmonton. British Columbia: Miss F. McQuarrie, Vancouver General Hospital. Manitoba: Miss D. Ditchfield, Children's Hospital, Winnipeg. New Brunswick: Miss Marion Myers, Saint John General Hospital. Nova Scotia: Sister Mary Peter, St. Joseph's Hospital, Glace Bay. Ontario: Miss L. D. Acton, Kingston General Hospital. Prince Edward Island: Miss Georgie Brown, Prince County Hospital, Summerside. Quebec: Miss M. Batson, Montreal General Hospital. Saskatchewan: Miss A. F. Lawrie, Regina General Hospital.

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Chairman, Miss K. Connor, Central Alta. Sanatorium; Vice-Chairman, Miss C. Feisel, Holy Cross Hospital; Sec., Miss M. Richards, Holy Cross Hospital; Treas., Miss M. Watt, City Health Dept.; *Conveners of Sections*: *Hospital & School of Nursing*, Miss J. Connal, Gen. Hospital; *Public Health*, Miss A. Dick, City Health Dept.; *General Nursing*, Miss D. Cannon, Gen. Hospital.

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Chairman, Miss C. E. Mary Rowles, Medicine Hat General Hospital; Vice-Chairman, Miss M. Hagerman, Y.W.C.A., Medicine Hat; Secretary-Treasurer, Miss M. Webster, 558 Fourth Street, Medicine Hat.

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Registered Nurses Association of Nova Scotia

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Chairman, Miss M. Stewart; First Vice-Chairman, Rev. Sr. M. Evangeline; Sec. Vice-Chairman, Miss P. Walker; Sec.-Treas., Mrs. E. M. Smith, 149 Laurier Ave. W., Ottawa; *Councillors*: Misses V. Belier, W. Cooke, M. Lowry, K. McIlraith, Mrs. G. Fraser; *Conveners*: *Hospital & School of Nursing*, Rev. Sr. St. Godfrey; *General Nursing*, Mrs. G. Fraser; *Public Health*, Miss F. Moroni; *Cornwall Chapter*, Miss M. McWhinnie; *Pembroke Chapter*, Rev. Sr. M. Evangeline; *The Canadian Nurse*, Miss H. Tanner.

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PRINCE EDWARD ISLAND

Prince Edward Island Registered Nurses Association

Pres., Miss Katharine MacLennan, Provincial Sanatorium, Charlottetown; Vice-Pres., Miss Mary Devereaux, New Haven; Sec., Miss Anna Mair, P.E.I. Hospital, Charlottetown; Treas. & Registrar, Rev. Sr. M. Magdalen, Charlottetown Hospital; *Chairmen of Sections*: *Hospital & School of Nursing*, Miss Georgie Brown, Prince Co. Hospital, Summerside; *General Nursing*, Miss Dorothy Hennessey, Charlottetown Hospital, Charlottetown; *Public Health*, Miss Margaret Darling, Alberton.

QUEBEC

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SASKATCHEWAN

Saskatchewan Registered Nurses Association (Incorporated 1917)

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Regina Registered Nurses Association

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A.A., Edmonton General Hospital, Edmonton

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